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The Newsweekly for Pharmacy

C&D

25 October 2003

Responses to DoH 'Vision' published

SOS campaign seeks Charter referendum

Wholesalers hit back at MHRA report

A bitter pill – what's next for generics?

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CROO HEAL

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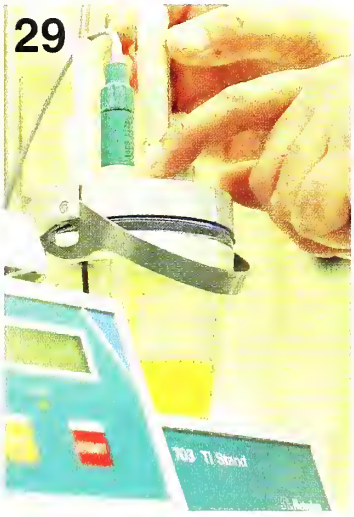

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Sasa Jankovic reports on the Department of Health's long awaited proposals for a new system of reimbursing the cost and supply of generic medicines for the NHS

London LPCs criticise 'Vision'

London's community pharmacists have criticised the Government's latest 'vision' for pharmacy, saying that it does not go far enough.

"Few new concepts are explored and little support is offered to the major issues within community pharmacy today," the London LPC Forum, which represents nearly 2,000 community pharmacies, told the Department of Health in its response to the consultation, *A Vision for Pharmacy in the new NHS*.

Saying that the chief pharmacists' 10 key roles for pharmacy lacked "imagination and vision", the Forum added: "The paper misses an opportunity to link roles with service description and design support."

Although welcoming the development of new roles and the need for a skill mix review, the Forum said that its own vision for pharmacists' aspirations "exceeded that of the chief pharmaceutical officer.

"Our local populations benefit from community pharmacists, who respond to the divergent ethnic mix of the capital and are accessible in pharmacies located in the heart of their community," it said.

Some of the points the Forum is calling for include:

- an overhaul of national funding mechanisms and a local assurance on continuity of funding
- Government support for development of premises and staff, clinical governance strategic integration and a will to commission and fund services in the long term
- community pharmacist inclusion in PCTs' decision-making arrangements and for CHAI to review the process by which pharmacists are appointed within PCTs' senior management and boards
- an acceleration of pharmacists becoming supplementary prescribers
- a unified London healthcare IT strategy
- a more stable community pharmacy environment, which will allow investment in service development; and
- the abolition of VAT on NRT.

There is minimal Government support for premise development, the Forum said, and called for money to be ring-fenced for pharmacies in deprived areas for premise improvement.

The problem of innovative community pharmacy services, which are withdrawn due to a lack of PCT investment, is another Forum concern.

"This stop/start behaviour does not help the smooth development of community pharmacy. Community pharmacy is also not best placed to negotiate the service developments with all 302 PCTs in England and many of these PCTs do not have adequate resources invested in this process."

The NPA, PSNC and the Royal Pharmaceutical Society have also responded to the DoH's consultation.
See p14 for further details.

Locum pharmacists have a significant part to play in developing new roles for the profession, a pharmacist insurance agency has said in response to the DoH's *Vision for Pharmacy* consultation.

"The [chief pharmacist's] 10 key roles contain many ideas that are worthy of support, however they appear to be very location driven and overtly emphasise the role of the community pharmacy, or the role of the pharmacist in the community pharmacy setting," said the Pharmacists' Defence Association, which provides services for 9,000 pharmacists.

"We believe that there are many as yet unexplored opportunities that become apparent when one considers the possibilities of recognising the individual pharmacist as a service provider/contractor providing services in a variety of locations," it said.

"The locum population, if organised properly, could provide specialised services in a highly flexible and cost effective way. For example, a specialist diabetic pharmacist locum could run a diabetic clinic in community pharmacy number one on a Monday, a GP surgery on Tuesday, community pharmacy number two on Wednesday and in a hospital on Thursday and Friday."

Got a query? Ask Gill

Are you confused by the Royal Pharmaceutical Society's modernisation agenda?

Next week, *C&D* will run a Q&A column in which readers are invited to send in queries, to be answered by RPSGB president Gill Hawksworth.

Send questions by e-mail with your name to *cdeadrug@cmpinformation.com* or by post to *C&D*, CMP Information, Sovereign House, Sovereign Way, Kent TN9 1RW or by fax to 01732 367065.

SOS group petitions for Charter referendum

Campaigners opposed to the Royal Pharmaceutical Society's modernisation agenda have launched a petition to force the Society to hold a referendum on its new Charter.

Former Council member Hassan Argomandkhah, who launched the petition on behalf of the Save Our Society campaign this week, wants the RPSGB to hold a referendum to establish the level of support for the proposed Charter. This was one of the motions passed by members at the special general meeting on June 1.

"The issue here is much more than whether the SOS or any one member of the RPSGB supports or rejects the new Charter; the fundamental issue is about the erosion of our democratic rights as ordinary members of the RPSGB," he said. "For Council not to hold a referendum in case they do not get the result they seek is not an option."

He added: "The new Charter will be the most fundamental change in the 160 year history of this professional body since the original Charter was granted in February 1843. Therefore it must be every members' right to have the final say."

He will present the petition to RPSGB president Gill Hawksworth at the Society's headquarters on December 2 prior to the Council meeting at which the Charter will be discussed.

Members who support the petition should write 'I support the call for a referendum on the draft Charter' followed by their name and registration number and either post it to: HA Chemist, 7B Baileys Lane, Halewood Village, Liverpool, Merseyside L26 2XB, or e-mail to *argomandkhah@blueyonder.co.uk* or fax to 0151 280 5137 or text to 07751 892 777, by December 1.

AAH says independents need not fear deregulation

Independent contractors must ensure that the services they offer meet the needs of their local community if they are to remain viable in a marketplace with no entry controls, according to AAH Pharmaceuticals.

Although the Department of Health's proposed exemptions to pharmacy control of entry regulations would make it easier for supermarkets to exploit the potential of their pharmacy offering, "the market for pharmacy is far from capacity", said AAH Pharmaceuticals marketing director Mandeep Mudhar.

"The independent community pharmacist has nothing to fear as long as they focus primarily on their service provision to customers. Focusing on service provision will be the key for community pharmacists," he said at a London briefing last Friday.

He highlighted four emerging trends that will dictate community pharmacy's future direction. These are the public's growing awareness of self-care, an increased consumer demand for convenience when accessing healthcare, more consumers seeking a one-to-one consultation with pharmacists, and increased competition.

But he warned that the next challenge for pharmacists would be to get funding from primary care trusts.

Although AAH had been in discussion with many PCTs, he said: "It is damn hard work getting through to the PCT and getting them to understand pharmacy and what it does. PCTs at the moment are very reluctant to put pharmacy high up on the agenda."

AAH Pharmaceuticals group managing director Steve Dunn predicted that pharmacies could be split into three different categories in the future. Some could become prescription factories providing a service for other pharmacies; some could embrace the new pharmacy contract and all its service provisions, while the remainder could become convenience stores similar to those in the USA.

Referring to last week's DoH proposal to claw back £200 million by reducing pharmacists' reimbursement for four key generic drugs (*C&D, October 18, p4*), Mr Dunn warned that this money was helping to fund today's pharmacy service and that its removal casts a doubt on future service provision.

He predicted that community pharmacists would lose further revenue as a result of the DoH's initial inquiry into reimbursement for generics. "There is no doubt that in rebalancing the *Tariff*, Government will move money out of generics [reimbursement]."

Welsh Executive backs Charter

The Royal Pharmaceutical Society's Welsh Executive has "wholeheartedly" endorsed the Society's revised draft Charter.

"Particular support was expressed by the inclusion of the object to safeguard, maintain the honour and promote the effectiveness and interests of the profession of pharmacy," the Executive said.

Chairman Andrea Robinson said: "The revisions to the draft have fully addressed the issues raised by the Executive in response to the 'Changing the Charter' consultation."

Script numbers jump 5 per cent

Pharmacists and appliance contractors dispensed over 567 million items in England for the year ending March 2003, an increase of 5.25 per cent.

The total cost of the items increased by 4.4 per cent to over £6,585 million, with an average cost per item of £11.61, according to the Prescription Pricing Authority's annual report for 2002-2003.

Nucare convention

Nucare's next annual convention – its 10th – will be held at Stratford upon Avon from Friday May 21 to Sunday May 23, 2004. Further details will be announced shortly.

Lloyds issues staff alarms

Lloydspharmacy is giving all its employees a personal alarm this month. The initiative will minimise any risk to staff while at work and out and about, says the company.

NPA makes IT appointment

The NPA has appointed Nigel Cox as its pharmacy systems development executive. Mr Cox, who was formerly part of the Flexiscript ETP consortium, will be charged with influencing the development and use of IT in community pharmacy.

Tritace correction

Aventis Pharma will be changing its Tritace capsules to tablets, and not Novartis as stated in last week's *C&D* (*p27*). *C&D* apologises for the error in the manufacturers' names.

For more information:

Aventis Pharma

Tel: 01732 584000.

Contract update

This is the last column in PSNC's series on the new pharmacy contract. Preliminary ballot of the new pharmacy contract – your contract, your future.

PSNC urges all contractors to vote in the preliminary ballot on the service framework of the new contract.

The service framework, which PSNC has developed in negotiations with the Department of Health and the NHS Confederation, consists of essential services, to be provided by all contractors, enhanced services that will require accreditation of the pharmacist and/or the premises, and additional services, commissioned locally by PCTs from a national menu with agreed service specifications. More detail on the service elements can be found on the PSNC website: *www.psnc.org.uk/contract*.

The response from the summer roadshows suggest that contractors are happy with the service framework, their greatest concerns being to secure fair funding for the service and adequate time to prepare for change.

Commenting on the ballot, Sue Sharpe, chief executive of PSNC, recently said: "It is important, as our negotiations on the services, fair funding and implementation progress, that contractors show their support for the new service framework, to demonstrate that, with the right support, funding and an acceptable contractual environment, pharmacy contractors are willing to develop their NHS services."

This preliminary ballot is seeking that support, so we can negotiate future funding confident of the value we can deliver for the NHS. You will have a further opportunity to consider and vote on the services, funding and implementation before any final decision is taken.

The question put to ballot, which asks for a yes or no response by October 29, is:

'I am happy with the outline service framework for the new contract, provided that it is supported by fair funding, an acceptable contractual environment and that a structured transition from the old to the new contract is in place.'

EDUCATION

Scots fund 100 more prescribers

The Scottish Executive is to fund 100 more community pharmacists to train as supplementary prescribers this year.

SPGC chairman Frank Owen was delighted with the news, which is the second tranche of money made available to Scottish pharmacists this year to support supplementary prescriber training (*C&D March 29, p5*). Encouraged by the over-subscription for places on the first course, Mr Owens argued the need to get more community pharmacists trained before the new contract comes in.

"Clearly the ability to act as a supplementary prescriber would significantly enhance the role of the community pharmacist in the proposed future provision of chronic medication services," he said. "It would be helpful, therefore, to recruit as many community pharmacists as possible before rolling out the new contract."

Chief pharmaceutical officer Bill Scott commented: "As one of the caring professions with an expertise in medicines, pharmacy needs to ultimately embrace independent and supplementary prescribing rights as a core function and not as additional qualifications. The successful negotiations by SPGC provide a further opportunity to help build a critical mass of community pharmacy practitioners in Scotland."

NHS Education Scotland is providing the funding. Its directo of pharmacy, Rosemarie Parr, sai the initiative should help to provide better access to medicines, make better use of community pharmacists' skills and improve the quality of pharmaceutical care, particularly for patients with chronic illnesse

Mr Owens is hopeful that further funding may be found or an ongoing basis to continue to allow all community pharmacists the opportunity to undertake the course.

Questiontime

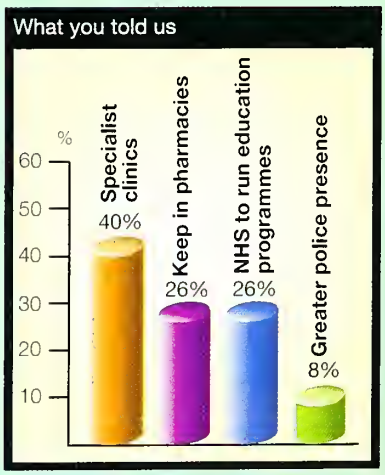
Sponsored by UniChem

Last week we asked you: "Welsh residents have vetoed a needle exchange service by harassing health professionals. How can this be overcome?" You replied (see right):

This week's question: Changes to stamp duty on leases will threaten pharmacies' viability. Which of the following locations is the most secure option to safeguard pharmacies?

- The high street
- Secondary shopping parades
- GP surgeries
- Primary care centres

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on October 28 to cast your vote. We will publish the results in *C&D*, November 1.



Pharmacists have role in tackling obesity incidence

A parliamentary lobby group has highlighted the role of community pharmacists in tackling the rising incidence of obesity in the UK.

Dorset community pharmacist Roger King warned of the health risks associated with obesity and, at an All Party Pharmacy Group meeting last Wednesday, said pharmacists have a greater public health role to play.

Too many pharmacists are engaged in passive health promotion with very little direct targeting of at risk patients, said Mr King, who has run a project that screened for CHD risk factors including obesity. The six million people who use community pharmacy daily are a captive audience and represented a "vast potential" for pharmacists to address the health issues surrounding obesity, he said.

However, pharmacists should focus on chronic disease rather than tackling obesity directly because many patients do not associate being overweight with

other health problems such as heart disease and diabetes. He suggested using diagnostic software to emphasise chronic disease risk factors to patients.

Highlighting PSNC's medicines management pilots, Mr King said: "Given the resources, pharmacists can play a significant part in reducing chronic disease." But if pharmacists are to make an impact in addressing public health issues, they need access to patient records and incentives to give up retail space for counselling areas, he warned.

Jim Smith, England's chief pharmacist, said the DoH's *Vision for Pharmacy* document highlighted pharmacists' public health role for the first time and this would be carried into the new contract negotiations. In addition, the DoH recognised the need for pharmacists to access certain parts of patients' records, and this was being addressed, he said.

UK Public Health Association chairman Geoff Rayner said that by 2010 a quarter of men and women in England could be classified as obese. He warned pharmacists that using medicines alone to tackle obesity was not the answer. Pharmacists must focus on non-medical interventions such as diet and physical activity and provide consistent advice to patients about obesity-related ill health. "It's a serious issue and pharmacists have to get onboard," he said.

POLICY

Push for legislation

Pharmacist and dispensing doctor representatives are now looking to the Government to translate accord on rural issues into legislation.

After finalising their joint position on rural dispensing last month, PSNC, the Dispensing Doctors' Association and the General Practitioners' Committee have now presented it to the rural affairs advisory group. PSNC's professional development and LPC services head, Mike King, said that the agreement looked to close the so-called 'loophole' in the Clothier regulations.

He said: "The hope is now that ministers will take on board the professions' concerns about changes to the control of entry regulations, rural issues and concerns about the exclusions. We hope the agreement will translate into regulations next year."

DDA chairman Dr Malcolm Ward said he was hoping to "see an end to the ceaseless speculation about the future of pharmaceutical services in rural areas".

Mika seeks OTC diclofenac

Mika Pharma has applied to the Medicines and Healthcare products Regulatory Agency for a POM to P switch for a topical diclofenac 4 per cent spray gel.

Comments on the proposal should be sent to the e-mail address below by November 26.

Novartis Consumer Health has applied to have Lamisil (terbinafine) AT 1 per cent Spray and Lamisil AT Cream reclassified as GSL medicines for the treatment of tinea pedis and cruris. Comments on the proposal should be e-mailed to: *amanda.lawrence@mhra.gsi.gov.uk* by November 27.

Launch of 'The Pain Initiative'

The management of common, everyday aches and pains is an important area of healthcare that is rarely discussed. To address this situation, **The Pain Initiative** has been established. **The Pain Initiative** is a multidisciplinary team of healthcare professionals who meet to discuss the latest developments in this area, sharing expertise and best practice regarding the management of everyday pain.

The current climate of high media interest in healthcare issues has re-enforced the need for a body like **The Pain Initiative**. Healthcare professionals are often confronted by consumers who have read about pain-related issues in their newspaper, which will often have taken a sensationalist angle on the subject. The challenge for the healthcare professional is to be aware of both the media angle and the evidence-based research on the subject, highlighting the connections and contradictions existing between the two.

The members of **The Pain Initiative** advisory board will meet on a regular basis and launch a number of new educational resources. The first of these will be a series of articles in *Chemist & Druggist* (starting next month), focussing on 'Pain Management'. The articles will focus on specific types of pain, giving advice on the best approach to its management.

The participants of the introductory advisory board meeting, which was held in London, were:

Dr Dipak Kanibar
Consultant Paediatrician, Guys Hospital, London

Julia Lucas
Practice Nurse, Liskeard and former chair RCN Practice Nurse Association

Dr Lee Kayne
Community Pharmacist, Glasgow

Dr Lester Russell
GP, Portsmouth

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WHOLESALERS

Supplier fury at MHRA report

Pharmacy suppliers have hit back with anger at the Government's decision to publish details of their inducement schemes, which it found to be in breach of drug advertising and promotion rules.

This week, the Medicines and Healthcare products Regulatory Agency somewhat belatedly named AAH Pharmaceuticals, Nucare and Numark as offering schemes in breach of drug 'inducement' rules, as they offered benefits that were neither inexpensive nor relevant to the practices of pharmacy. The report says: "Any activities which try to persuade health professionals to prescribe, purchase or supply medicines by means of inducements, are a serious breach of trust.

"At the request of the MHRA, all three schemes have been withdrawn or amended and we will continue to monitor this area closely."

AAH is particularly furious over the inclusion of its 'buy and fly' (Vantage own-label) scheme in the report, since this was withdrawn over a year ago at AAH's own initiative, and because the replacement scheme had had the MHRA's approval since January. Moreover, at the time it was scrapped, the now defunct promotion was worth only £2.70 to the average pharmacy, AAH has estimated.

AAH marketing director Dr Mandeep Mudhar said: "We are very cross to be included and are appalled at the arrogance of the MHRA. We are comfortable that we have done the right thing every step of the way and this leaves something of a sour taste. Who knows why they are making such a big deal out of this when it was resolved ages ago?"

Numark is also incensed at the MHRA's actions.

In January, Numark introduced the Beneficial Share Scheme, which linked Numark member pharmacists' wholesale purchase levels to an option to subscribe to Numark shares at a discount.

Shortly after its launch, the MHRA challenged the scheme as not complying with its drug promotion rules. Despite disagreeing with the MHRA interpretation of the laws, Numark terminated the scheme in June.

Numark managing director David Wood said: "The literal interpretation that the UK authorities are now giving to the legislation is effectively preventing companies such as Numark from introducing innovatory price schemes and is a long way removed from the mischief of the legislation in question.

"The independent pharmacy retail sector is increasingly under threat. I regret the failure of the UK authorities to consider the larger picture of encouraging active competition in the independent retail and wholesale pharmacy market."

Representatives from Nucare were unavailable for comment.

"

"

Dr Mandeep Mudhar

WHOLESALERS

IVAX loses Advantage in favour of low prices for all

Ivax Pharmaceuticals UK has ditched its Advantage membership scheme in favour of a simplified, low prices for all scheme called IVAX First.

Open to all UK pharmacists and dispensing doctors from November 1, the new pricing programme aims to deliver products at a net market price, with no sign up or data release requirements, retrospective discounts, spend thresholds or other "trickery", explained Richard Daniell, director of UK Generics at IVAX Pharmaceuticals UK. "Advantage members had flagged up to us how time-poor healthcare professionals are these days, and that there were time issues associated with the Advantage scheme redemption system.

"We have listened, and the result is a straightforward purchasing opportunity that offers instant price benefits. IVAX First is, first and foremost, about competitive prices. The net market price is totally transparent. What you see is what you get."

The pricing programme will be supported by a monthly price list, twice-daily deliveries and website. The company pledges to keep its first to market promise, and says key launches for next year include pravastatin, ciclosporin and clarithromycin. All products are in IVAX's new patient packs, claimed to be the blueprint for the MCA's latest guidelines on medicines labelling and packaging.

For more information:
www.ivaxfirst.co.uk

Aedes aegypti: one of the species of mosquito known to carry the yellow fever virus. Yellow fever is characterised by fever, muscle pain, headache, shivers, loss of appetite and nausea. Often, high fever is paradoxically associated with a slow pulse. 15% of patients enter a 'toxic phase' within 24 hours. The patient rapidly develops jaundice and complains of abdominal pain with vomiting. Bleeding can occur from the mouth, nose, eyes and/or stomach. Kidney function deteriorates, sometimes resulting in complete kidney failure with anuria. Half of the patients in the toxic phase die within 10-14 days.[2]

(1) National statistics 2001 edition. (2) World Health Organization www.who.int/en/ Date of Preparation 04/03 2812

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nt sites at the same time or with an interval of 3 weeks between them. Immunoglobulin may be
at a different site, at the same time. Yellow fever vaccine should only be given to elderly and
ated patients if it is considered that there is a notable risk of yellow fever infection during travel.
sirable effects: Injection site reactions; systemic reactions such as fever, headache,
a, asthenia, rash, urticaria and lymphadenopathy; stiffness with fever, tiredness and
ches may occur 4 to 7 days after vaccination; very rarely, neurological disorders such as
itis, encephalitis or meningoencephalitis; anaphylactoid reactions have occurred very rarely.
are cases of yellow fever-like illness have been reported, some of which have been fatal.

Package quantities and basic NHS cost: Single pack containing vial of lyophilised powder with 0.5 millilitre syringe of diluent, basic NHS cost £23.00

Marketing authorisation holder: UK - Aventis Pasteur MSD Limited, Mallards Reach, Bridge Avenue, Maidenhead, Berkshire SL6 1QP; Ireland - Aventis Pasteur MSD Limited, Belgard Road, Tallaght, Dublin 24.

Marketing authorisation number: UK - PL6745/0087 (lyophilised vaccine), PL6745/0088 (diluent); Ireland - PA 544/31/1

Legal category: POM

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RA358/0703 Date of last review: June 2003

Lease duty changes will cost retailers millions

Changes to the stamp duty on leases will drive up prices, cost jobs and damage regeneration, employers' representatives are warning.

Lease duty on rent payable is currently based on the length of the lease and the average annual rent. Under the new system, which comes into effect on December 1, lease duty will be based on the net present value of the total rent payable.

The CBI, for example, estimates that a retailer leasing a shop for 25 years at an annual rent of £120,000 would currently pay £2,400 duty. Under the new rules, the firm would pay about £19,000 – eight times more.

The CBI, which represents UK employers, believes the Government has understated how many leases will be affected by its changes and has overestimated the present value of leases.

Hardest hit are likely to be retailers and consumer service firms such as pubs and restaurants which, it warns, between them will have to find millions of pounds for the Treasury coffers.

Supporting the CBI's calls, the NPA says that, on behalf of members, it is prepared to add its voice to the lobby.

CBI director-general Digby Jones said: "Duty increases on this scale will be damaging. This tax hike could easily swing the balance against marginal projects, undermining regeneration and costing jobs. Long-term investment will be hit as firms look for shorter leases."

Schering cuts back pharmacy sales force

Schering Healthcare is to shed a number of jobs from its primary care sales force as part of an overall corporate reorganisation designed to improve efficiencies.

The losses, the exact number of which have not been disclosed, arise from a reduction in the size of Schering's individual sales territories.

Under the new plan, rather than have multiple representatives covering a larger area, individual representatives will now cover a larger number of smaller sales areas.

At the same time as making the cuts in the primary care team, Schering is aiming to increase its specialist sales force by around 80 per cent. This primarily serves hospital MS and oncology specialists.

This increase comes on the back of new product and marketing initiatives in the specialist sector as well as a historical under-resourcing, said a company spokesman, emphasising that the cuts in primary care will not lead to a loss of focus on that sector.

The plans, which also include moves to transform the company into a business unit-led organisation, should take effect from January.

New procedures guide

PSOP (Pharmacy Standard Operating Procedures) has published a manual outlining general operating procedures in independent pharmacy.

The 300-page document, *Standard Operational Procedures Manual*, contains reference information on cash handling and administration, stock control and management, product merchandising and marketing, customer relations and protocols, staff training and employment law, health and safety, workplace security procedures, dispensing – professional conduct, advisory staff notices and supplier contact information.

PSOP's select consultative committee includes members of Northants LPC, including secretary Bob Allison. Commenting, PSOP operation chief Christopher Middleton said: "Our primary objective is assisting pharmacies to improve the community services they provide, ensuring all independent operators are kept aware of their changing legal obligations. The PSOP manual... offers essential protection for both employer and employees."

The *Standard Operational Procedures Manual* is priced at £299.

For more information:
www.psop.co.uk

Nicorette Patch is specifically designed to be taken off at bedtime, so the body gets a break. It's a discreet, easy-to-use, once-a-day dose available in three strengths so your customers can gradually reduce their nicotine intake. The new Nicorette Patch TV campaign featuring the benefit of "the patch you take off at night" starts soon. So give your customers Nicorette Patch and help them beat cigarettes one at a time.

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United response seeks adequate resources

The three main pharmacy organisations have responded to the Department of Health's *Vision for Pharmacy*. summarises

All three main pharmacy organisations have stressed the need for adequate funding for the roles proposed in the Department of Health's *Vision for Pharmacy*.

While the Royal Pharmaceutical Society, the National Pharmaceutical Association and the Pharmaceutical Services Negotiating Committee broadly welcomed the consultation's proposals, all three share similar concerns, particularly about remote supervision of pharmacies.

The Society welcomed the move towards a contract based on quality as well as volume, but said "progress and development must be sustainable". Pharmacists cannot provide enhanced services without the resources to do so. The volume of NHS dispensing has risen by 40 per cent over the past 10 years, meaning that about the same number of pharmacists "are coping with a hugely increased workload even before engaging with the new agenda".

The NPA agreed that pharmacy owners must be able to make returns on their investment in new services, to ensure sustainability.

PSNC said adequate funding is the main factor to be considered in setting out new roles. Funding for training of all pharmacy staff is necessary to ensure service development, including IT skills and patient safety. Fair funding would also give pharmacists incentives to update their premises by, for example, providing consultation areas for medicines reviews.

PSNC is also concerned about the transfer of global sum payments to PCTs and the development of 'local contracts'. National negotiation with the Department and NHS Confederation is the best way to deliver a pharmacy contract that maximises benefits for patients and the NHS. Future devolution of sums to PCTs must include safeguards to protect monies needed for fair funding of essential pharmacy services.

The Society pointed out that putting too many services out to local commissioning could lead t postcode access to pharmacy services. PCTs with resource problems might decide that commissioning new pharmacy services is not a high priority.

There is also concern over whether services would be commissioned on a short-term basis rather than a long-term contract. Pharmacists are more likely to invest in innovative services when they are confident that funding will be sustained.

All three organisations had misgivings about pharmacies being left without a pharmacist for periods of time. The Society

said: "It is important to balance the need for pharmacists to delegate tasks to sufficiently trained support staff, with the public's expectation of being able to see a pharmacist at a time that is convenient to them."

Any new proposals must ensure patient safety and maintain a high standard of care at all times, the Society added, suggesting any proposals are adequately piloted and rigorously evaluated to ensure patient safety is not compromised.

The NPA agreed that before there is any change, new dispensing models should be tested under tightly controlled conditions so the public can be as confident in them as in the traditional model. And any change in the interpretation of supervision will require careful scrutiny of training requirements for all pharmacy staff.

It would also be essential for models that exclude direct pharmacist involvement to be acceptable to the public, other healthcare professionals and commissioners of healthcare, as well as pharmacy staff.

PSNC commented: "It seems inconceivable the Department should, on the one hand, highlight and encourage provision of pharmacist managed services and, on the other, suggest that community pharmacies can be managed from afar."

Among the NPA's other concerns is the conclusion that if some pharmacies focus on the provision of highly efficient dispensing services, they will relieve other pharmacies of dispensing workloads. "Assuming remuneration will still be linked to dispensing, it is hard to see how this conclusion can be drawn. Moreover, experience suggests dispensing workload is related to one main factor – location."

The NPA is also concerned at the lack of detail on the robust IT infrastructure needed and on the access community pharmacists will have to patient records.

The Society argued that meeting the costs of upgrading the hardware and software needed for NHSnet connection would give a powerful signal to the rest of the NHS that community pharmacy is an integral part of it.

Other points raised include:

- Integration of PMS and LPS schemes could bring benefits in closer working between professionals, but could reduce patient choice and ease of access.
- PSNC is disappointed that the Department has missed another opportunity to move towards full patient pack dispensing.
- A community pharmacist should sit on the professional executive committee of all PCTs and there should be increased PCT liaison with local pharmaceutical committees.
- Any strategy for tackling health inequalities must use the current network of community pharmacies. PCTs must consider carefully the effects of one-stop primary care centres on the pharmacy network.
- There is a need to change the public's and primary healthcare team's attitudes to community pharmacy so it is better recognised as an integral part of the NHS.
- There should be a national training and support programme for PCT pharmaceutical advisers and PEC pharmacists.
- A toolkit should be developed to help PCTs assess pharmaceutical needs to help them commission local pharmacy services.

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NPA

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RPSGB

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PSNC

For more information:

www.rpsgb.org.uk
www.npa.co.uk
www.psnc.org.uk

Comment from the Editor

As the consultation period on the DoH's *Vision for Pharmacy* closes, a flurry of responses is outlined in *C&D* (*p4, 14*).

Seen collectively, there is general support for the *Vision*, although the London LPCs' response argued that it does not go far enough. It also contains some novel suggestions – for example, to end VAT on NRT – that could be achieved fairly swiftly and have a crowd-pleasing effect.

An interesting point now getting a second airing is that of whether the new pharmacy contract should be linked to the pharmacy or the pharmacist providing the services. Already hinted at by Scottish chief pharmacist Bill Scott at BPC, the insurance company The Pharmacists' Defence Association says that not only has the impact of the high proportion of locums in the pharmacy workforce not been taken properly into account, but that there could be benefits in allowing the pharmacist to have a contract that can be used in various settings. The fact that this view in turn overlooks the investment in premises current contractors make seems to have been missed, though.

With the matter of pharmacy deregulation still not sorted out, the AAH view on the matter is quite bold (*p6*). Independents have nothing to fear from deregulation provid they focus on service provision, says AAH. This will please some and worry others for different reasons. Is it the first weakness in an impressive barrage of anti-OFT lobbying by (generally) united pharmacy sector or is it a realistic appraisa of the Government's signalled intentions and an offer of support from one of the several companies providing much more than a straight forward wholesaling business?

Whatever, the news that the Government still hasn't mastered the concept of joined-up thinking may scupper an plans for a new and improved pharmacy service at the heart the community. Business leasehold stamp duties (*p9*) could l the straw that will break the high street's back.

Is it the first weakness in an impressive barrage of anti-OFT lobbying?

Cymrucomment

Cath O'Brien looks at the Welsh Assembly's decision to provide free prescriptions in Wales

The essentials for Wales....

The Welsh Assembly's commitment to free prescriptions in Wales was reinforced in health minister Jane Hutt's announcement earlier this month that all prescription charges would be reduced by £1 by October 1, 2004 – bringing the cost of prescriptions in Wales down to £5. She went on to pledge free prescriptions for all by the end of this term, in 2007.

There are still questions that need to be addressed, such as how will funding for this policy be structured and does it include Pharmacy medicines? Ms Hutt also alluded to an increased role for pharmacists and multi-professional consultations: the Welsh Executive will be closely monitoring any developments. At the very least, the prescription policy does mean that Wales will break away from standard prescription charges currently in

place across England and Wales.

This is not the only area in which healthcare may be delivered differently for the people of Wales. The new pharmacy contract will embrace and underpin service development in community pharmacy. Negotiations are currently taking place between the Department of Health, NHS Confederation and PSNC for England and Wales.

However, the Welsh Assembly Government has the right to opt out of any aspects that do not synchronise with the pattern of healthcare delivery in Wales.

By adapting the contract to suit the needs of Wales, the Welsh Assembly may be able to pursue its commitment to supply free prescriptions for all more easily.

The Assembly has set up three working groups on which the Welsh Executive has representation. These are:

- A New Contract Group that will scope the development of services, systems and training needed to meet the new contract.
- A Direct Supply Group to develop a scheme for supply from pharmacists to patients for Minor and Self Limiting Conditions.
- A Repeat Dispensing Group to develop a repeat dispensing scheme for Wales.

Work is also underway for the Supplementary Prescribing Tas and Finish Group, whose remit to develop and introduce an accredited training programme enable nurses and pharmacists t be trained as supplementary prescribers.

A Wales-specific multi-professional course will be developed with separate programmes for pharmacists ar provided via six centres in Wal

In implementing all of these is going to be vital for pharmac to be connected to NHSnet. *Informing Healthcare – the Wels Assembly strategy for IT provisio in Wales* – has created a bluepri for planning the IT infrastruct in Wales for the next 10 years.

The connection of communi pharmacies to NHS Cymru W is the essential building block t develop and move forward wit these agendas in Wales.

Reader REPLY

The new contract

It looks as if part of the new contract will be rolled out in April 2004 exactly as laid out by PSNC originally. This means that either no regard has been taken by PSNC of any suggestions from the members or there were none. What's the point of the ballot? How can we have part of a contract without knowing what comes after, without knowing how and what funds are available?

Let's face it, none of us can disagree with any of the proposals put forward for community pharmacy. But there are inherent dangers we must look out for:

- Additional services open to all community pharmacists and not at a whim of local pharmaceutical officers, as it is now.
- Inadequate funding for basic outgoings of a pharmacy if payment for dispensing is cut, leaving only multiples who can absorb their remaining losses.
- Additional services being given to a contracted pharmacist by the PCT, bypassing community pharmacies as is happening now.

How can we have part of a contract without knowing what comes after

- Uniform payments for additional services throughout the country and uniform provision of services, not localised as it is now.

I suggest the new contract be simple with a core payment enabling pharmacies to stay open.

Also, however much we protest about leaving technicians without pharmacists on site, it's going ahead despite the fact that in hospitals with a predominance of technicians, there are at least three major mistakes a day.

Finally, PSNC has decided to become a limited company with six elected members from multiples with a resultant cost to independents. There was no consultation with members who pay millions towards its existence. What a curious time to do so. Perhaps, like the Government, PSNC tried to 'bury' this with the bad news of the new contract.

Elisabeth Hopkins, Ealing.

TOPICAL REFLECTIONS

Balancing a utopian dream

From an academic viewpoint the announcement of the first full local pharmaceutical service (LPS) pharmacy sounds like community pharmacy Utopia (*C&D October 18, p8*).

The pharmacy is only open to referred patients who are on and have been assessed as requiring medication management. They must also satisfy criteria for referral that could drive a coach and horses through the Government's avowed policy of encouraging patient choice. The pharmacy is open from 9am to 5pm Monday to Friday but only 10am to 4pm for patients. No OTC medicines are sold but a minor ailments scheme for the supply of medicines for self-limiting conditions is planned, as is supplementary prescribing.

Since only repeat medication to identified patients is dispensed, the workload can be planned, stock can be kept to a minimum and awkward problems like OTC medicines sales, free advice and acute prescriptions, even from registered patients, can be avoided.

But this LPS dream come true could be at the cost of a more pressurised and less cost-effective service from nearby pharmacies. To pay for the LPS an identified sum will have been removed from the global sum and the number of prescriptions dispensed by other pharmacies reduced. They will also be dispensing a higher proportion of acute prescriptions since many of the repeat prescriptions will have been directed to the LPS. The opportunity for supply side profit will also have been reduced, as stock levels will rise in proportion to the unpredictability of the remaining demand and the increased competition for the now smaller NHS cake.

So what next? Perhaps an LPS application in Salford for supplying substance misuse clients, a contract to supply all the PCT controlled residential and nursing homes or perhaps a diabetic referral and monitoring scheme that allows monitoring and prescribing for all diabetics to be conducted by one dedicated pharmacy. I am sure a good LPS case can be made for these services and more, to the point where the community pharmacy service easily accessible to those in need ceases to exist.

The last community pharmacy then left will itself become an LPS specialising in dealing with all those difficult problems none of the others wants to deal with. All that is then needed is for the Medicines and Healthcare products Regulatory Agency to enthusiastically change the remaining P medicines to GSL and the annihilation of community pharmacy will be complete.

Don't overlook the benefits of the OTC sector

After all the publicity to encourage the public to take responsibility for their own health and despite the best promotional efforts of the pharmaceutical industry, sales of OTC medicines are still stagnant.

Simon Fradd, chairman of the Doctor Patient Partnership, has claimed this may be due to a public perception that OTC medicines are not sufficiently potent and that 'real' medicines can only be obtained on prescription (*C&D October 18, p4*).

Simon may be partly correct but his idea of a leaflet handed out with dispensed medicines indicating they can also be purchased over the counter would merely scratch the surface of the problem. A far more radical suggestion would be for community pharmacists to withdraw from their pre-occupation with changes in the NHS and concentrate a little more on their other core activity, selling medicines.

Last week's *C&D* included an excellent supplement entitled *Winter Remedies* and a poster, sponsored by Pfizer Consumer Healthcare, designed to educate the public on how they can help themselves to limit the problems of the common cold. That poster is now on prominent display in my pharmacy and my winter remedy window is already installed.

The pharmacy is still the first port of call for customers seeking OTC medicines. Their sales should be rising and that they are not may partly be our fault. The NHS is only one part of my business and not necessarily the most profitable. Sustained promotion of OTC medicines throughout the year should be second nature to all community pharmacists. If it is not then we really only have ourselves to blame that sales are not achieving expectation.

ReaderREPLY

Needle exchange withdrawal was 'wrong'

I am saddened and concerned with the recent events in Wales that have resulted in pharmacy contractors withdrawing a valuable needle exchange scheme (*C&D, October 18, p6*), and I condemn those that perpetrated the cowardly hate mail campaign.

Working in a very deprived area of Belfast, I have had my fair share of problems, so I do empathise with those pharmacists involved. However, I feel that the decision to withdraw the service was wrong and may damage their pharmacy services locally and perhaps even nationally, for many years to come.

Yes, pharmacy is dependent on customers for survival and any threat must be considered carefully. But pharmacy is also a profession and in this context we must provide the services that are needed in our communities and be advocates for those services, even in the face of opposition.

Withdrawing services just because we fear a negative impact on our businesses may prove to be inordinately short-sighted.

I doubt primary care organisations in Wales, who will be left to deal with the problem of supplying clean syringes, will look kindly on these contractors when additional services are being commissioned. And, of course, this has happened before, when a multiple pharmacy group in Manchester withdrew its EHC service, just because they encountered some negative press.

This is a crucial time for pharmacy, especially as we are about to embark on negotiations for a new contract. We must make sure we are participating in the public health business, and yes, sometimes this isn't rosy.

Terry Maguire,
vice-chairman,
PharmacyHealthLink.

Please e-mail your views to *chemdrug@cmpinformation.com*

Lambeth OUTLOOK

Catch of the day

RPSGB director of public affairs, Beverley Parkin, gives her views on the party political conferences

At last month's party political seaside conferences, the health fringe meetings were alive with shoals of brightly coloured ministers and their shadows promising choice, freedom, values, responsibility and delivery.

This year, at the Labour and Liberal Democrats' conferences, the pharmacy organisations teamed up with leading think tanks to host fringe meetings on the future of the NHS.

Addressed by big fish, ministerial level speakers, these meetings provided a good opportunity for the profession to engage with key thinkers and decision-makers and to probe the direction of travel in the NHS.

At the Labour conference it was clear that the profession features in the Government's future plans for the NHS. John Hutton MP, the NHS minister and a rare catch, addressed both of the pharmacy fringe meetings and deftly managed to give different yet complementary speeches.

Asked to address the issue of who should run the NHS – politicians, patients or professionals? – he seized the question like a killer whale. The old management frameworks in the NHS were out of date. Managers no longer perceived the top-down approach of ministers bearing down on NHS staff as a good working method. It had failed patients and professionals.

Instead, he said, the Government sees patients at the apex of the NHS. He was keen to point out that patients will be key to the running of foundation trust hospitals, playing a major part in the new governance arrangements. And of course, the watchword for patients in PCTs is also "involvement" through the Commission for Patient and Public Involvement in Health.

On rousing form, Mr Hutton directly addressed the values, principles and culture of delivery within the NHS. He pointed out that Nye Bevan, the founding father of the NHS, had always said that the methods of delivery in the NHS would and should change as the service grew and evolved. I suspect that Mr Bevan did not expect to be spinning in his grave to quite that extent.

A number of other senior and well respected speakers also mad valuable contributions. James Strachan, chair of the Audit Commission, made it clear that much NHS policy was posited around the concepts of economy efficiency and effectiveness. In obsessively measuring these elements, the Government had g itself into a situation where these targets had become an obstacle t improvement.

Julia Neuberger of the NHS think tank, the King's Fund, argued for further devolution fo the NHS, with the creation of a arms-length NHS agency that would remove control from the secretary of state. She pointed o that the depoliticisation of the Bank of England had worked we and that the same principle woul hold true in the health sector.

Fringe meetings highlighted t range and vibrancy of thinking offer for the NHS today. Perhap the most telling was the Government's willingness to concede that acute care had dominated the agenda for too lo and the time to focus on primary care and the management of chronic conditions has come.

Let us hope, now that our MP have been emptied back into the Westminster goldfish bowl, that they demonstrate rather longer memories than their piscatorial equivalents.

Dr Christine Clark reviews current understanding of the pathology of psoriasis, recent advances in its management and measures to improve the safety and effectiveness of treatment

Managing psoriasis

THE COLLEGE OF PHARMACY PRACTICE
This course (module 1285), in association with multiple choice questions being published in C&D November 1, provides one hour's continuing education

- To revise signs and symptoms of psoriasis
- To appreciate precipitating factors
- To know when to refer to a GP
- To know which treatments to apply to which site
- To be able to support patients

Psoriasis is a chronic inflammatory skin disease that affects 2-3 per cent of the UK population. The disease usually starts between the second and third decades of life or in the sixth decade, although it can start at any age.

The cause of psoriasis is not known but many of the features are well described. Inheritance appears to play a part in predisposing some individuals. About one third of patients have a family history and a number of genetic markers have been found in association with the condition.

The most common form of psoriasis is chronic plaque psoriasis. Typically this presents as well-defined, thickened, red plaques covered with silvery scales. If the scales are scratched or removed, characteristic pinpoint bleeding is seen (Auspitz's sign).

Psoriasis may appear at almost any site on the body but the most commonly affected areas are the scalp, the extensor (outside) surfaces of the limbs (typically shins and elbows) and the lower back. In flexures it appears as red, shiny skin without the usual scaling and it may feel tight and sore. These areas, where the skin is thinner, can be more sensitive and require particular care in the selection of treatments.

The fingernails and toenails are affected in about 50 per cent of cases and 5-10 per cent of people with psoriasis also have an associated arthropathy.

The major abnormalities in psoriasis are:

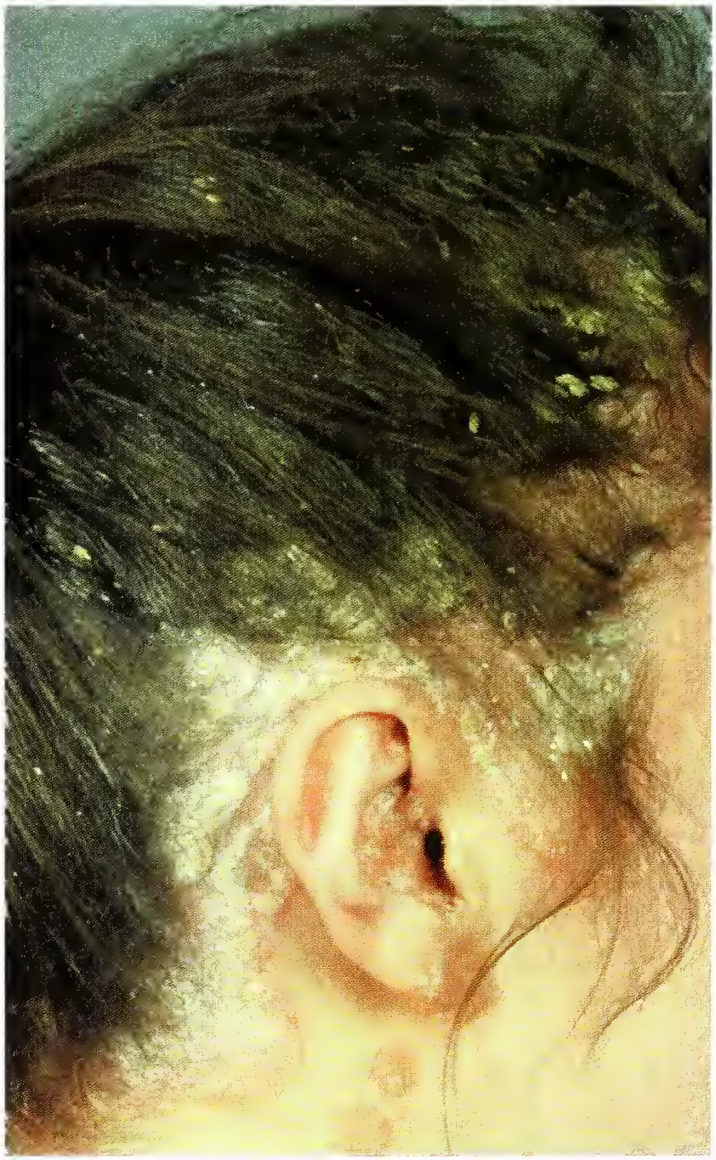
- hyperproliferation of the epidermis, leading to thickening and scaling
- abnormal differentiation of keratinocytes
- infiltration of the dermis and epidermis with activated T-lymphocytes and neutrophils
- stimulation of the cutaneous vasculature.

Cell-mediated immune mechanisms appear to be driving these processes, with activated T-lymphocytes playing an important role in the development and maintenance of the psoriatic plaque. A variety of stimuli, including the release of cytokines from keratinocytes, are thought to attract and activate T-lymphocytes, which go on to release a battery of cytokines.

These further stimulate keratinocyte proliferation and in this way the condition is propagated. Although these immunological reactions clearly play an important role in the condition no triggering antigen has been found and new approaches to treatment have focused on the use of drugs that can block T-cell activation, migration or cytokine secretion.

Molecular biologists have shown that the activation process involves two steps. First the T-cell binds to an antigen presenting cell through an interaction between two adhesion molecules – the integrin LFA-1 on the T-cell surface and the ICAM-1 on the antigen-presenting cell. (The integrin LFA-1 and the adhesion molecule ICAM-1 are both cell surface proteins that recognise and stick to each other.) This stimulates the first signal. A

Continued on page 20 ▶



John Radcliffe Hospital/Science Photo Library

Side view of the head of a young woman suffering from psoriasis, a chronic skin disease in which itchy, scaly, red patches form on the skin, particularly that of the elbows, forearms, knees, legs & scalp. It is one of the commonest skin diseases, affecting about 2 per cent of the British population, but its cause is unknown

secondary or co-stimulatory signal is required to bring about T-cell activation. This occurs through binding of several pairs of ligands on the surfaces of the two cell types. Once activated, T-cells express interleukin-2 (IL-2) receptors and secrete IL-2, which stimulates T-cell proliferation.

This understanding of events at a molecular level has provided a basis for therapeutic intervention. For example, alefacept has been licensed for the treatment of psoriasis in the USA. Alefacept is a fusion protein that selectively binds to activated T-cells and prevents a co-stimulatory signal from being sent, thereby reducing the number of activated T-cells. Infliximab, a monoclonal antibody directed against the effector cytokine TNF-alpha, and etanercept, which competitively binds TNF-alpha, have also been studied in psoriasis and appear to be effective for inducing remission.

Psoriasis is a relapsing and remitting condition, which accounts for much of the distress caused by the disease. Even when the condition is in remission, it could flare up at any time and this imposes a heavy psychological burden. Although the exact mechanisms are not understood, a number of precipitating factors have been identified that may trigger episodes of psoriasis in susceptible individuals.

Precipitating factors include:

- trauma – scratches or surgical wounds in active psoriasis. Surgery in an area of active psoriasis can result in a florid keloid scar (Koebner phenomenon)
- infection – guttate psoriasis is often triggered by pharyngitis caused by beta-haemolytic streptococci
- hormonal events
- sunlight – this usually improves psoriasis but 10 per cent of cases worsen on exposure to sunlight
- drugs – beta-blockers, antimalarial agents and lithium can worsen or precipitate psoriasis
- alcohol
- cigarettes
- psychological stress – profound psychological stress, such as bereavement or divorce, can trigger psoriasis.

When to refer

Patients should be referred to a doctor in the following situations:

1. A severe flare up of psoriasis that does not respond to the patient's normal treatment.
2. A severe or widespread flare up, especially if the face, palms, soles or genitalia are affected and if accompanied by feelings of general malaise. This could indicate rare but serious conditions such as erythrodermic psoriasis, when most of the body surface is inflamed and there is a risk of severe heat, fluid and protein loss. Another rare condition is generalised or palmo-plantar pustular psoriasis. Generalised pustular psoriasis is usually accompanied by swinging pyrexia and can occur following withdrawal of long-term topical steroids.
3. Patients receiving topical steroids for psoriasis on repeat prescriptions should be monitored carefully. Clinical reviews should occur every four to eight weeks. If topical steroids are prescribed on a repeat prescription, without review, for a longer period the patient should be referred to confirm that continued treatment is intended.
4. Failure of appropriately used topical treatment after two to three months.
5. A rebound flare up of psoriasis after stopping topical steroid treatment.

Treatment guidelines

Most patients with chronic plaque psoriasis have mild disease that can be managed in a primary care setting using topical treatments. The remainder have moderate to severe disease that requires second line treatment, often involving phototherapy or photochemotherapy (PUVA), and/or systemic drug treatment under supervision of a dermatologist.

Recently published guidelines for the initial management of psoriasis from the British Association of Dermatologists (BAD) and the Primary Care Dermatology Society (PCDS)[1] are shown in box 1.

Vitamin D analogues

In recent years vitamin D analogues have become the mainstay of treatment for chronic plaque psoriasis. They inhibit keratinocyte differentiation and proliferation and have weaker effects on calcium metabolism than vitamin D itself. Unlike the traditional tar and dithranol treatments they do not smell or stain and neither do they carry the risk of skin atrophy seen with topical steroids. It has been shown that vitamin D analogues may be as effective as use of a potent steroid, only with a longer duration of remission following discontinuation of treatment.[2] The available products are calcipotriol, tacalcitol and calcitriol.

Skin irritation, resulting in increased redness, dryness and stinging or burning, can be a problem and for this reason calcipotriol should not be used on the face or flexures. Calcitriol is significantly less irritating and is suitable for use on the face and sensitive flexural areas.[3]

The maximum weekly amounts of the vitamin D analogues are limited to avoid the risk of hypercalcaemia (calcipotriol – 100g, calcitriol – 210g and tacalcitol – 70g).

Topical steroids

Topical steroids are pleasant to use because they do not smell, stain or cause irritation and are often effective for bringing a flare up under control. These advantages have to be balanced against the risks of local side effects such as skin atrophy, striae, telangiectasia and the risk of rebound and worsening of psoriasis after discontinuation. An additional problem is tachyphylaxis – that is, the need for increasing amounts in order t achieve the same effect as treatment progresses.

Mild potency topical steroids are used for psoriasis affecting th face, flexures or genitalia, while potent steroids are used for recalcitrant lesions on the trunk or limbs. The use of steroids in psoriasis treatment requires careful supervision and the BAD has formulated guidelines for their safe use (*see box 2*). The moderate potency steroid, clobetasone butyrate 0.05 per ce may not be sold for the treatmen of psoriasis.

Pharmaceutical car

In discussion with patients and carers it is important to emphasi that psoriasis is not infectious an that it cannot be cured, but it ca be controlled. As can be seen fro the treatment guidelines, a patie may have several concurrent topical treatments. It is importan to ensure that the patient understands which product to apply to which site, the quantity

Box 1: Initial treatment of chronic plaque psoriasis*

- **Emollients** should be used to soften scale and reduce irritation.
- For **localised plaque psoriasis**, for example elbows or knees, one or more of the following:

A tar-based cream or tar/corticosteroid mixture.

A moderate-potency topical corticosteroid such as clobetasone butyrate 0.05 per cent; more potent agents may be used on areas of thicker skin such as palms, soles or on the scalp.

A vitamin D analogue such as calcipotriol, calcitriol or tacalcitol (*see below*). The latter two are less irritant and are more suitable for use on the face or flexures but should still be used with caution.

Calcipotriol with betamethasone dipropionate as a combination product. **Note:** long-term data regarding relapse rates are not yet available.

A topical vitamin A analogue (tazarotene).

Short-contact dithranol treatment.

- For more **widespread plaque psoriasis** for example, on trunk or limbs, the same treatments may be appropriate. **Note:** Dithranol is impractical if there are multiple small lesions and will irritate flexures. Topical corticosteroids may be inappropriate for long-term use on large areas. Application by suitably trained nurses may overcome these problems.
- For **scalp psoriasis** one or more of:

A tar-based shampoo.

Plus 2-5 per cent salicylic acid preparation or a coconut oil/tar/salicylic acid combinatio ointment.

A potent topical corticosteroid preparation such as betamethasone valerate.

Calcipotriol scalp application.

Note: A keratolytic agent should be used first if the scale is thick.

- For **psoriasis affecting the palms and soles**, where there is usually thickening and inflammation: keratolytic agents potent corticosteroids, tar and vitamin D analogues.
- For **psoriasis affecting the flexures** milder agents are used: low potency topical steroids, mil tar preparations and calcitriol or tacalcitol.
- For **psoriasis affecting the face** use emollients and mild agents: low potency topical steroids, mild tar preparations and calcitriol or tacalcitol.

**New BAD/PCDS guidelines (2003)*

to be applied and the method of application. For example, steroids should be applied thinly whereas vitamin D analogues should be applied more generously (*see Update C&D, June 16, 2001, pI-IV*). Time spent on these points may be critical to the effectiveness or otherwise of the prescribed treatment.

The fingertip unit (FTU) is commonly used to describe the quantity of the topical steroid required. It is the amount covering the distance from the tip of the patient's index finger to the first joint as the preparation is squeezed out of the tube (based on the standard nozzle diameter of 5mm). Using this as a guide, suitable amounts would be:

- For the trunk (back or front) – seven FTUs
- A leg – six FTUs
- An arm – three FTUs
- Face and neck – 2.5 FTUs
- A foot – two FTUs
- A hand – one FTU.

There are also a number of day-to-day practical problems caused by the disease where pharmacists can help to support patients with psoriasis:

- Shedding of skin scales can be reduced by frequent application of suitable emollients.
- Painful cracking and bleeding of plaques on the hands can be reduced by the use of emollients to restore pliability to the skin and the use of emollient soap substitute to prevent further drying.

Smoking and drinking alcohol can be precipitating factors for psoriasis

For many patients psoriasis will be a lifelong condition and so it is important to provide up-to-date information about available treatments, their effectiveness, side effects and practical considerations so that patients can decide on what is most suitable for them. Sources of information include patient support groups (*see end of article*), pharmaceutical companies and local dermatology specialist centres.

Surveys have shown that patients are often disappointed with the results of prescribed treatment. Inadequate information about how and where to apply topical products almost certainly contributes to this, as well as inadequate information about alternative treatment options.

Community pharmacists, who often have regular contact with patients, can play an important role in helping to ensure that the BAD/PCDS guidelines are followed, responses to treatment are monitored and treatment is modified if necessary. This kind of approach can increase the effectiveness of treatment and improve the patient's quality of life in this distressing condition.

References:
1. British Association of Dermatologists and Primary Care Dermatology Society. Recommendations for the initial management of psoriasis. 2003. www.pcds.org.uk accessed September 26, 2003.
2. Camarasa JM, Ortonne J-P, Dubertret L. Calcitriol shows greater persistence of treatment effect than betamethasone dipropionate in topical psoriasis therapy. J Dermatol Treatment 2003;14:8–13
3. Ortonne J-P, Humbert P, Nicolas JF et al. Intra-individual comparison of cutaneous safety and efficacy of calcitriol 3(g g-1 ointment and calcipotriol 50(g g-1 ointment on chronic plaque psoriasis localised in facial, hairline, retroauricular or flexural areas. Brit J Dermatol 2003; 148:1–8.
4. Guidelines for the management of psoriasis. J Dermatol Treatment 1997; 8: 27–55.

Useful contacts:
The Psoriasis Association, 7 Milton Street, Northampton NN2 7JG, tel: 0184 711129.
The Psoriatic Arthropathy Alliance, PO Box 111, St Albans, Herts AL2 3JQ, tel: 01923 672837. www.paalliance.org

Pharmacist and freelance writer Dr Christine Clark is a part-time senior research fellow in clinical therapeutics, University of Bradford School of Pharmacy.

Actionplan

1. Review the proprietary/generic name and strength of topical preparations used for the treatment of psoriasis.
2. Review the problems associated with the use of topical tar products.
3. The BAD guidelines say: "No topical steroid should be used regularly for more than four weeks without critical review". Do you think this rule is followed by many of your GPs for psoriatic patients? If not, what are you going to do about it?
4. In your practice workbook write a protocol that outlines advice you would give to psoriatic patients
- on how to apply their topical medications
- on the use of non-prescription topical products such as emollients.

5. How do you distinguish between scalp psoriasis and other flaky scalp conditions? What would you recommend for these other conditions? List them in your practice workbook.
6. Read section 13.5.2 on "Preparations for psoriasis" in the *BNF*.

Box 2: BAD guidelines for the management of psoriasis – topical corticosteroids[4]

- No topical steroid should be used regularly for more than four weeks without critical review.
- Potent corticosteroids should not be used regularly for more than seven days.
- No unsupervised repeat prescriptions should be made: patients should be reviewed every three months.
- No more than 100g of a moderately potent or higher potency preparation should be applied per month.
- Attempts should be made to rotate topical corticosteroids with alternative non-corticosteroid preparations.
- Use of potent or very potent preparations should be under dermatological supervision.
- The fingertip unit is a measure that helps patients to know how much ointment or cream to apply (*see Pharmaceutical care*).

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded to test. With the support of Genus Pharmaceuticals, C&D's readers can self test their progress through the multiple choice question (MCQ) paper to be inserted in the November 1 issue, which will cover this week's CPP-accredited module, together with those in the October 4 and 18 issues.
These will cover:
● **Bipolar disorder (1283)** ● **Coeliac disease (1284)** ● **Psoriasis (1285).**
A telephone marking service offers independent verification of results – please call the monthly MCQ papers.
People wanting to register for Pharmacy Update can contact Mary Peebles on 01732 377269.

C&D in association with GP

GENUS PHARMACEUTICALS

Greater stroke risk for hypertensive HRT users

Women with hypertension should not be given hormone replacement therapy because it increases their risk of stroke, say Danish doctors.

Postmenopausal women with normal blood pressure who are taking HRT are at no greater risk of stroke, add the researchers.

The study found that hypertensive women using combined HRT of oestrogen and progestogen were at a slightly higher risk of stroke than those who used oestrogen-only preparations.

A spokeswoman for the Stroke Association said: "[The association is] aware of a number of studies indicating a connection between hormone replacement therapy and increased risk of stroke. The results of many of these studies have been mixed. We recommend that any woman considering using HRT or currently using HRT who is concerned, should discuss their concerns with their doctor."

Of the 13,000 women involved in the study, 114 suffered an ischaemic or haemorrhagic stroke within five years of the start of the study. The researchers say that stroke normally affects one per 1,000 women aged 45 to 65 each year.

For more information:

www.archneurol.com

Arch Neurol 2003; 60: 1379-84.

Rofecoxib causes fewer GI side effects than naproxen

Osteoarthritis patients taking rofecoxib are significantly less likely to discontinue treatment due to GI side effects than patients taking naproxen, say researchers in the USA.

The three-month study of 5,557 patients showed that rofecoxib 25mg daily was as effective a painkiller for osteoarthritis as naproxen 500mg twice daily. However, the rofecoxib patients reported better GI tolerability, and were less likely to need additional medication to treat GI symptoms.

The researchers also compared the effects of the two drugs on hypertensive patients, and found no significant difference in BP control. A notable limitation of the study was the regular daily dosing schedule followed, as osteoarthritis sufferers tend to use medication less consistently and in response to symptom flare up.

Osteoarthritic patients taking rofecoxib seem to suffer fewer side effects than those taking naproxen, according to researchers in the USA

The Merck Sharpe & Dohme funded research was carried out in the USA and Sweden as part of the multi-centre ADVANTAGE study.

For more information:

www.annals.org

Ann Internal Med 2003; 139: 539-546

Atopic eczema treatments for children compared

The effectiveness of tacrolimus ointment and pimecrolimus creat for reducing the symptoms of atopic eczema in children depend on treatment duration, suggests new research.

The study found that nearly 40 per cent of 193 children aged fro two to 15 whose moderate to severe atopic eczema was treated with tacrolimus ointment (0.1 pe cent, Protopic) were clear or almost clear of symptoms after si weeks compared with 20 per cent of children who were treated wit pimecrolimus cream (1 per cent, Elidel). However, after the first week of the study, more patients (4 per cent) using pimecrolimus were clear or almost clear of thei lesions than those using tacrolim (3.2 per cent).

Patients using tacrolimus reported fewer incidences of burning skin and a lower assessment of itching than those using pimecrolimus.

Dr Alan Fleischer, one of the researchers on the study funded by Protopic manufacturer Fujisawa, said: "These exciting results clearly show the superior efficacy of tacrolimus ointment i children with moderate to severe disease, without compromising patient safety."

The data was presented at the European Academy of Dermatology and Venereology meeting in Barcelona.

For more information:

JEADV 2003; 17 (Suppl 3): October 15-18.

Metformin is first choice for PCOS

Metformin is an effective treatment for anovulation in women with polycystic ovarian syndrome, but should be an adjuvant to a healthy lifestyle and not a replacement, say researchers.

Analysing the data from 13 trials, the researchers conclude that metformin's position as first choice for treating anovulation seems justified. They add that metformin's long-term safety profile is unknown and there is only a small amount of data available on its use in the early stages of pregnancy.

Metformin produced a significant increase in pregnancy rates when compared with placebo, the researchers reported in the *BMJ*. Clomifene and metformin together were more effective than metformin alone, the researchers found.

Overall, metformin or metformin and clomifene increased ovulation rates by 57 per cent. However, the researchers conclude that greater ovulation rates were achieved in studies where women improved their lifestyle with more exercise and weight loss.

For more information:

BMJ 2003; 327: 951-5

www.bmj.com

Improving lifestyle with exercise and weight loss can help improve ovulation

Scriptlines

Additions to ZD list

PSNC has announced that the following items will be added to the ZD section of November's *Drug Tariff*.

List A: Ether Solution BP, Humira Injection, mefenamic acid suspension 50mg/5ml, Merional Injections, Videx EC capsules (125mg, 200mg, 250mg, 400mg).

List B: paracetamol suppositories (120mg, 240mg), Proctosedyl suppositories, ViraferonPeg injections.

Additionally, ZD will be applied to all prescriptions for Hepsera Tablets dispensed from September.

For more information:

PSNC
www.psnc.org.uk
Tel: 01296 432823.

Acer move for Pennsaid

Acer Medical has taken over responsibility for Pennsaid Cutaneous Solution (diclofenac sodium 16.05mg/ml).

Pennsaid is licensed for the localised treatment of osteoarthritic pain in superficial joints. The basic NHS cost of a 60ml bottle remains £16.00, and the product is now available via wholesalers.

For more information:

Pip code: 277-0485
Acer Medical
Tel: 0800 781 3642.

Supply problems with Stilboestrol

APS Berk has announced that stilboestrol 1mg and 5mg tablets will not be available until early 2004. This is due to supply problems with the raw material.

For more information:

APS Berk
Tel: 01132 380099.

Zamadol Melt

Viatris has launched Zamadol Melt, the first orodispersible tramadol preparation.

The 50mg tablets are designed to melt on the tongue, and have a mint taste. The product is licensed for the management of moderate to severe pain. The basic NHS price for a pack of 100 tablets is £12.77.

For more information:

Pip code: 294-4445
Viatris Pharmaceuticals Ltd
Tel: 01223 205999.

Frontshop

Palmolive Thermal Spa

Palmolive is launching Thermal Spa, a range "inspired by the healing aspects of water and enriched with natural thermal minerals".

It is available in three variants: Purifying (as bath foam containing thermal minerals), Hydrating (as shower gel or bath foam and containing thermal minerals, algae extract and moisturising beads) and Massage (as a gently exfoliating shower gel containing white clay, massaging micro-spheres and thermal minerals).

The range aims to give consumers "the sensation of a detoxifying, rejuvenating and moisturising spa experience in the home".

Targeted at 25-40-year-old women who are looking for luxury products which use natural ingredients, the range's transparent packaging is in "ocean-inspired" blue and aquamarine colours.

Palmolive is planning a marketing campaign for 2004 to support the launch.

Price: Shower gels £1.99, bath foam £2.49

Pack size: shower gels 250ml, bath foam 500ml
Pip codes: see *Price List*
Colgate-Palmolive
Tel: 01483 302222.

Macleans highlights health and beauty

Macleans toothpaste is having a major makeover which GlaxoSmithKline hopes will redefine the oral care market.

The new look, which includes a new logo, colours, branding and 'health and beauty' inspired language, will improve shelf stand-out and brand differentiation. It will align the brand "more closely to the burgeoning health and beauty market," says the company.

Each toothpaste variant has its own graphic and colour for easier identification, and terminology new to the brand such as 'Powerful' Freshmint and 'Pristine' Ice Whitening further emphasises the health and beauty message.

The new identity has been extended to mouthwashes and toothbrushes. Phase-in starts now with a £1.8 million marketing campaign later in the year.

For more information:

GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 5000.

Kleenex bear essentials

Kimberley-Clark is promoting the Kleenex range with a free winter survival kit and the activation of its National Cold and Flu website.

Consumers can claim their Bear Essentials kit by collecting tokens from promotional packs of Kleenex tissues. Each kit contains a selection of free samples and money off vouchers along with one of three Bear Essential bears.

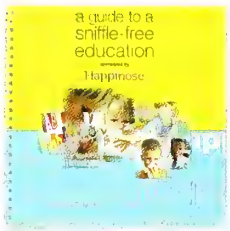
The website contains survey information and news relating to cold and 'flu patterns in the UK.

For more information:

www.wintersurvival.co.uk
Kimberley-Clark Ltd
Tel: 01732 594000.

Frontshop

Education guide from Happinose



Dendron is promoting Happinose through a free customer booklet and a new advertising campaign.

The *Guide to Sniffle-Free Education* will be available to customers from October 27. The company hopes the booklet will help parents tackle the difficulties they encounter regarding their children's education.

The guide includes information on choosing schools and guidance on exams and private tutoring.

There is an additional section on diagnoses and treatment options for common childhood ailments.

The new advertising campaign will run in the woman's weekly magazines from the beginning of November until the end of January. Copies of the booklet can be obtained by telephoning 020 7761 1739.

For more information:
Dendron Ltd
Tel: 01923 229251.

Spread the Forte word

Bioforce is fostering friendships this cold and 'flu season with Echinacea Forte. Special packets contain one extra strip of 10 blister pack tablets for customers to pass on to a friend to try.

Bioforce says that many of its customers come to the range through recommendation from a friend. It says that its Echinacea Forte Friendship Pack helps customers to spread the word.

Price: £7.99
Pack size: 50 tablets
Pip code: 287-1515

Bioforce
www.bioforce.co.uk
Tel: 01294 277344.

Nectar Ease buzzes into pharmacy

Nectar Ease Manuka honey and bee venom products are being introduced into the pharmacy arena.

Combining New Zealand bees' venom and pure Manuka honey, the company claims the products may help ease the effects of everyday aches and pains, joint stiffness and pain associated with arthritis.

Nectar Ease is available as honey, in capsules (suitable for diabetics) or as a balm. Nectar Ease Plus is available as a honey or in capsule form and contains glucosamine sulphate in addition to the bee venom.

As part of its support for the pharmacy sector, Nectar Ease UK has produced a sample-size introduction pack.

This includes 120g Nectar Ease Honey and 10g Nectar Ease Balm, enough to last approximately one week, and costs £3.99.

For more information:
Nectar Ease UK
www.nectarease.co.uk
E-mail: enquiries@nectarease.co.uk
Tel: 0800 7830942.

Scriptlines

Updated SPC

The SPC for Salofalk rectal foam (1g mesalazine per actuation) has been updated to incorporate an increase in shelf-life from two to three years.

All other product information remains unchanged.

For more information:
Provalis Healthcare Ltd
Tel: 01244 288888.

Duac gel for acne

Stiefel is introducing Duac Once Daily Gel for mild to moderate acne.

The Prescription Only Medicine contains clindamycin phosphate 1.28 per cent (equivalent to clindamycin 1 per cent w/w) and hydrous benzoyl peroxide 6.67 per cent (equivalent to anhydrous benzoyl peroxide 5 per cent w/w) in a homogenous gel, and does not need to be reconstituted before dispensing. It will appear on wholesalers' systems on October 27, and will be available from November 4.

For more information:
Basic NHS price: £9.95
Pack size: 25g
Pip code: 298-8400
Stiefel Laboratories (UK) Ltd
Tel: 01628 524966.

CE spells devices

PSNC has warned contractors that they will not be reimbursed for dispensing medical devices that are not listed in the *Drug Tariff Part IX*.

Problems have arisen due to items changing category from medicinal products to medical devices, and not being listed in *Part IX*. Affected products include Baxters Sodium Chloride for Irrigation. PSNC advises checking the packaging for any unusual prescribed item as a CE mark indicates that the product is a device.

For more information:
www.psnc.org.uk

Silky Blistex

Dendron is expanding the Blistex lip care range with the introduction of Blistex Silk & Shine.

The product is said to condition, protects and enhances lips. It contains silk extracts to moisturise, and an SPF15 to protect against the sun.

Price: RSP £2.25
Pack size: 4.25g
Pip code: 297-9094
Dendron
Tel: 01923 229251.

“PACKET IN ”

New NiQuitin CQ® 4mg Mint Lozenge

The unsurpassed efficacy of original NiQuitin CQ® Lozenge, in a fresh new flavour.

For those who smoke within 30 minutes of waking, this power, combined with your support, could be just what they need to quit.

Nicotine

Help bring smoking to a full stop

Frontshop

Four hand sign for 4-bladed Quattro

Wilkinson Sword has unveiled the imagery for its Quattro promotional campaign which breaks on Sunday (*C&D October 18, p30*).

To reinforce the four-blade razors, the ads will visually reference Quattro's 4 hand sign which has been adopted as a key symbol of the brand and which will be exploited across all media throughout the campaign.

Targeted at 18-34-year-old males, the campaign will include advertising on television, print media, radio, the internet and in posters. The 30-second advert airs on ITV, Channel 4, Channel 5 and satellite stations, with high visibility during sport and male-orientated programming.

Other promotional support includes an integrated PR campaign, highly targeted sampling, retailer activity and viral marketing. Point of sale material, including specially designed CTUs and FSDUs, "will create impact and high visibility at retail, supporting Quattro's leading-edge and premium status", says the company.

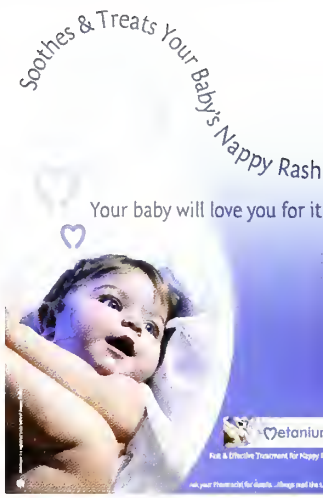
For more information:
Wilkinson Sword
Tel: 01494 533300.

Metanium's winter suppor

Ransom Consumer Healthcare will be running an intensive promotion campaign for Metanium Ointment starting next month.

Running for six months, the campaign includes single page advertisements in leading parenting titles *Mother & Baby* and *Prima Baby*. These will run alongside a nationwide competition launched in the November issue of *Prima Baby* to find the Metanium Face of 2004.

In addition, Metanium will be promoted via Pharmasite in November and December and a sampling and detailing campaign will run in the first four months of 2004 with a new Metanium Nappy Rash leaflet being distributed via Bounty's professional network package.



For more information:
Chemist Brokers
Tel: 023 9222 2500.

L'Oréal goes to extremes

L'Oréal is adding Color Resist cream eye shadow to its make-up range. The manufacturer claims the product is waterproof and crease-proof for up to eight hours, and will resist "almost everything". The glide-on formulation is available in five shimmering shades and comes in a clear and silver tube.

Price: RSP £5.99

Pip code: see *Price List*
L'Oréal Group UK
Tel: 020 8762 4000.

Inbrief

Ester-C

Zila Nutraceuticals is launching a £350,000 PR-based campaign to keep Ester-C in consumers' minds. Ester-C ascorbate is a patented, non-acidic, natural form of vitamin C. It is an ingredient in many vitamin C branded products.

For more information:
Martin Last
Zila Nutraceuticals (marketing)
Tel: 020 8804 7290.

TV next week

Askit Powders: STV, C4, C5
Clearblue Digital Pregnancy Test: All areas except U, CTV, GMTV
Just for Men: GTV, STV, B, G, Y, TT, C4, C5
Lloydspharmacy's Diabetes Testing Service: GTV, STV, B
Oilatum Scalp Treatment: Sat
Sensodyne Total Care Extra Fresh: U
Seven Seas Neutra Taste: C5, GMTV, Sat
Seven Seas Pure Cod Liver Oil: C4, C5, GMTV, Sat
Solpadeine: U
Tena *lady* & Tena *pants* Discreet: All areas except U, GMTV

PharmaSite for next week: Tixyplus – window, **Care range Fluconazole –** in-store, **Metanium –** dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

ALMUS

Award-winning Almus extends its range

Almus is expanding its award-winning generic medicines range with a further selection of products, available for purchase through UniChem and OTC Direct...

The innovative aim of Almus is to aid dispensing – to give pharmacists and patients continuity of packaging, to increase safety of dispensing, and to increase dispensing efficiency thus giving pharmacists the time they need to focus on patients.
This month, the Almus range expands further to include the following:

- Amiodarone Tablets 200mg, 28's
- Amiodarone Tablets 100mg, 28's
- Amitriptyline Tablets 10mg, 28's
- Amitriptyline Tablets 25mg, 28's
- Amitriptyline Tablets 50mg, 28's
- Bumetanide Tablets 1mg, 28's
- Co-Dydramol Tablets 10/500mg, 100's
- Digoxin Tablets 62.5mg, 28's
- Digoxin Tablets 125mg, 28's
- Digoxin Tablets 250mg, 28's
- Ferrous Sulphate Tablets 200mg, 28's
- Gliclazide Tablets 80mg, 28's & 60's
- Nitrazepam Tablets 5mg, 28's
- Propranolol Tablets 10mg, 28's
- Propranolol Tablets 40mg, 28's

harmacy Business Generic Product of the Year 2003
r Metformin

"We are both heartened to see so much positive effort at last going into pharmaceutical design. The Almus range deserves to set a new standard and become a benchmark product for pharmaceutical packaging design."

Whittaker Hughes, Author of the Pharmaceutical Packaging Audit website

"The packaging will help reduce dispensing errrors and cut down on dispensing time"

Jas Matharu

Designed to aid dispensing

Only one is part of a pharmaceutical group that has been in continuous activity for 300 years.
Only one is now the largest generic company in the UK.

And only one is committed to staying number one by being your first choice.

There are many generic companies, but there is only one Generics [UK].

Generics [UK] Ltd

Committed to being your first choice

MERCK generics

Albany Gate • Darkes Lane • Potters Bar • Herts EN6 1AG
Customer Services Tel: 01707 853100 • Fax: 01707 662191 • www.generics.uk.com

A bitter pill?

The Department of Health claims its proposals for a new system of reimbursement for generic medicines will deliver a fair return for the supply chain. Saša Janković hears the suppliers' views

The Department of Health has published its long awaited proposals for a new system of reimbursing the cost and supply of generic medicines for the NHS following widespread consultation with the industry. This would replace the maximum price scheme introduced in 2000 following concerns over costs and availability of generic medicines.

Once agreed, the scheme would start in April 2004. Key points include the proposal that prices at which pharmacy contractors are reimbursed would be linked to prices charged by manufacturers and that information from manufacturers would be used to calculate the volume weighted average price.

The DoH is also proposing that there should be incentives for pharmacies to benefit from procurement decisions where these also benefit the NHS, and if there are a limited number of manufacturers of a generic medicine or the supply is concentrated, manufacturers would be required to seek the Department's agreement to any price increase.

Manufacturers and wholesalers would be required to submit quarterly information for generic medicines on their income revenues, cost of purchases and volumes of transactions, although how this would be policed is as yet unknown.

In addition, manufacturers could decide the prices of new generic products at their own discretion following the granting of a marketing authorisation, provided the drug tariff was less than the equivalent branded medicine. However, at the same time, the DoH is considering provisions that would prevent companies exploiting this freedom, although these criteria too have not yet been clarified.

PSNC chief executive Sue Sharpe says: "The proposals have three elements of particular importance to pharmacy: the price tracking mechanisms, based on quarterly

> The NHS spends over £1 billion each year on generic medicines in primary care. Seventy six per cent of prescriptions were written generically in 2002, with over 53 per cent of scripts dispensed generically the same year. If there were no generics the medicines bill would increase to £11.1bn, so generics provide a £4.6bn saving. Every 1 per cent increase in generics dispensed saves the NHS £39.2 million.

Continued on page 30

returns from manufacturers and wholesalers; the link between those prices and the *Drug Tariff*; and recognition that pharmacies must have incentives to purchase wisely for the NHS."

The NPA agrees that "the Government's new thinking on reimbursement is a significant improvement on the proposals put forward in 2001".

In a statement it says: "The DoH appears to have accepted that its initial options were detrimental to both pharmacies and the Government because they did not provide the NHS with the benefits to be gained by using pharmacy owners' entrepreneurial skills in purchasing."

Warwick Smith, director of The British Generic Manufacturers Association, adds: "The BGMA welcomes the Government's decision to undertake a full and wide ranging consultation before reaching a conclusion."

The DoH has also announced that *Drug Tariff* prices of four generic drugs – doxazosin, lisinopril, omeprazole and simvastatin – could be cut by up to half from December 1.

"There are currently significant differences between the reimbursement price and the price at which pharmacists purchase these four medicines from suppliers," the DoH said.

"The generic versions of these four medicines have entered the market since the last discount inquiry [in 2000] and are not included in the current calculation, at a significant cost to the NHS.

There comes a point at which it becomes commercially nonsensical to carry the range that is being carried

Steve Dunn

"Reducing the reimbursement price of these four medicines [to community pharmacists and dispensing doctors] will make sure that the NHS is getting value for money until new arrangements for the supply of generic medicines are agreed."

PSNC said it would discuss these proposals with the DoH in the context of the existing consultation.

British Association of Pharmaceutical Wholesalers chairman Steve Dunn has warned that because the proposal was being considered outside the ongoing consultation on generic reimbursement, it could lead to disruption. He warns that, although full line wholesalers are committed to maintaining a full service, "there comes a point at which it becomes commercially nonsensical to carry the range that is being carried".

In light of these proposals, what do the suppliers really think?

Russell Howard, Alpharma's managing director, says: "As a member of The British Generic Manufacturers Association, Alpharma has been fully involved in consultation with BGMA members in working with the DoH and other representative associations in the development of the reimbursement proposals. Alpharma does support the objectives for the new scheme set out in the Government's paper and welcomes the move towards greater transparency in arrangements. The Government's proposals, however, are complex and we are in the process of carefully considering them."

David Cole, chief executive officer at Phoenix Medical Supplies, agrees that the proposals only "sketch" a structure for determining the proposed reimbursement prices and supply chain profit allocation. He says: "It is impossible to quantify the commercial implications for the supply chain, based on the level of detail contained in the proposals.

"The method of fixing reimbursement prices moves from a top down approach – prices fixed relative to the brand equivalent based on a fair price the NHS is prepared to pay, to a bottom up with prices being fixed on manufacturer price, with a profit

Continued on page 32

listening

We're making our packaging even more accessible

We take your views very seriously. So we are refining the look of our cartons so they are easier for you and your customers to use.

- Enlarged product names
- Clearer end panels, for clarity on the shelf
- Twice as many colours, making each product and strength more distinctive
- Statutory warnings and route of administration notices, as per labelling best practice guidelines (MLX275)

We are listening. To find out more, talk with your Alpharma representative, visit our website at www.accessiblemedicine.co.uk or call us on 01271 311200. As you would expect from the UK's leading manufacturer of solid dose generic medicines.

100 years

ALPHARMA

Making medicine accessible

Alpharma Limited, Whiddon Valley, Barnstaple, Devon EX32 8NS

allocation for the supply chain.

"It would appear that the manufacturers would then have the most flexibility on price and supply, with wholesalers and contractors very limited in their competitive influence. The current competitive influence from contractors on determining market prices, with the incentive to do so, would be curtailed.

"The profit stream from generics currently for contractors and wholesalers cannot be viewed in isolation. If the current reimbursement profit for contractors is to be redistributed to reward the provision of extra services, the additional cost of providing these services has to be quantified. Similarly, wholesalers should require a level of return for providing the necessary service, and if this is currently being subsidised by generic margins, it will have to be redistributed into other areas."

Mr Cole also believes the required level of data provision to the DoH which would allow constant checking and monitoring of the market will require additional resources and costs from all parties.

"The current market conditions do allow manufacturers of a wide range of generic medicines to take an overall portfolio view of product prices," he says. "The proposals will inevitably lead to individual product scrutiny, which may result in reduced range and therefore reduced inter-company product competition. If this were to occur, we would witness increased prices and product shortages."

Terry Prudhoe from Aspar Pharmaceuticals believes that, for the most part, the UK generics market functions "extremely well".

"At the moment the market seems buoyant and it has received a major boost from the recent expiry of patents on major molecules such as omeprazole and simvastatin," he says.

"Until now it has been a very good example of how the free market really works, with prices generally being dependent on the balance between supply and demand.

"On the other hand, when the balance was seriously disturbed, as happened when the MCA shut down Regent, it did seem to be the case that certain prices went out of control. In the light of this, it is understandable that the DoH might want to implement a mechanism whereby it can prevent sudden price escalations.

"Unfortunately, they seem to have gone about it in a way typical of governments by imposing extra and probably unnecessary form-filling on the industry. Manufacturers will have to submit quarterly returns on their generic sales which seems to be a clumsy way of monitoring price increases and constitutes an additional bureaucratic load that brings only extra costs on the industry and no discernible benefits.

"A more logical approach would be for the DoH instead to continue to monitor pharmacists' request for payments on dispensed generics and only investigate when net ingredient cost for a particular product suddenly rose. At that point it would make sense for the DoH to ask all manufacturers and suppliers of that particular product to provide data on their sales volumes and revenues and explain any price rises.

"Such a system would be far less bureaucratic and simpler to implement. Presumably though, the DoH wants to be seen to be doing something about prices and perhaps the BGMA has declared itself to be reasonably happy because the alternatives that the DoH proposed were even worse?"

However, John Beighton, chairman of the BGMA and managing director of APS Berk, expressed disappointment at the consultation document, saying he was "particularly concerned" at the restrictions imposed on free pricing of generics.

"If a market is controlled it will be distorted and if there are distortions in a market there could be serious consequences," he says.

"Not allowing generic companies to increase prices, particularly of low value, high volume products, is likely to lead to those companies leaving the market instead. This will, I am certain, lead to shortages, and I don't mean shortages that mean pharmacists have to sho around a few wholesalers before they can fin the product; I mean shortages that mean patients really will go without their medicine

Mr Beighton will be urging the DoH to remove these restrictions so that price increases, as well as decreases are allowed. This will attract new suppliers which will lead to increased competition and subsequen price decreases.

"If the DoH removes these restrictions I believe that we could work with Government and pharmacy in order to ensure there will b a reliable supply of generics medicines to protect patients, there will be a fair return fo all parts of the supply chain – manufacturer, wholesaler and pharmacist, and the Government will achieve objectives of low priced generics and total transparency of pricing.

"I'm certain that we are not that far away from a generic reimbursement system that al parts of the supply chain can be happy with, as long as the DoH is willing to listen to sound economic argument."

John Davies, retail services director at Mawdsleys, agrees that in the interim the uncertainties will destabilise the market and continue to affect confidence in businesses throughout the supply chain. He says: "The options outlined in the government consultation document will inevitably force t market for generics to adjust to a new regim

"It is absolutely crucial that in reaching a workable pricing system for generics, the Do recognises the interdependence of the variou profit and non-profit generators for both wholesalers and retailers. Any scheme, whic results in diminished margins from generics will inevitably trigger higher prices or a reduction in discount in other categories, su

Manufacturers such as Eldon Laboratories feel that the route to success lies with an ability to adap to the special issues that pharmacy and industry have had to deal with in recent years

"The proposals will inevitably lead to individual product scrutiny, which may result in reduced range and therefore reduced inter-company product competition"

David R Cole

Continued on page 34

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le Name of the Medicinal Product
vastatin 10 mg Film-coated Tablets.
vastatin 20 mg Film-coated Tablets.
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rapeutic Indications
onary heart disease, hyperlipidaemia and homozygous familial
ercholesterolaemia
age
vastatin tablets are taken with a standard cholesterol lowering diet.
onary heart disease:
ting dose is 20 mg/day, dose adjusted gradually to a maximum of 80
day given as a single dose in the evening
erlipidaemia:
recommended dose is 10 mg (range 10-80 mg) once daily taken in
vening.
ozygous familial hypercholesterolaemia:
g/day taken as a single dose in the evening, or 80 mg/day in three
ed doses of 20 mg, and a 40 mg dose taken in the evening. In
erate hypercholesterolaemia (total cholesterol ≥ 6.5 mmol/l and <
mmol/l after diet) 5 mg/day may be given initially. In severe
rcholesterolaemia (total cholesterol ≥ 7.8 mmol/l after diet),
ment may be initiated at a dose of 10 mg/day.
omitant therapy
estatin tablets are effective alone or in combination with bile-acid
estrants. In patients taking cyclosporin, fibrates or niacin
omitantly the maximum recommended dosage is 10 mg/day.
tients with severe renal insufficiency (creatinine clearance <30 ml/min), dosages above 10 mg/day should only be implemented cautiously.

Contra-indications
Hypersensitivity to simvastatin, active liver disease or unexplained persistent elevations of serum transaminases; porphyria, pregnancy and breast-feeding; women of childbearing potential unless adequately protected by non-hormonal contraceptive methods.

Special Warnings and Precautions for Use
Simvastatin is not indicated in Types I, IV and V hyperlipidaemia.
It is recommended that liver-function tests be performed before treatment begins, and periodically thereafter.
The drug should be used with caution in patients who drink substantial quantities of alcohol and/or have a past history of liver disease.

Interactions with other Medicinal Products and other forms of interaction
Gemfibrozil and other fibrates, lipid-lowering doses (≥1g/day) of niacin (nicotinic acid increases the risk of myopathy when given concomitantly with simvastatin, probably because they can produce myopathy when given alone). Inhibitors of CYP3A4, i.e. cyclosporin, intraconazole, ketoconazole, erythromycin, clarithromycin, HIV protease inhibitors, nefazodone increase the risk of myopathy with simvastatin and grapefruit juice.
Simvastatin may increase digoxin blood concentration, when drugs are taken together.
Coumarin derivatives: Simvastatin modestly potentiates the effect of coumarin anticoagulants.

Undesirable Effects
Most common side effects in clinical trials were abdominal pain, constipation, flatulence, asthenia and headache. Myopathy has been reported rarely.
Other side effects are nausea, diarrhoea, rash, dyspepsia, pruritus, alopecia, dizziness, muscle cramps, myalgia, pancreatitis, paraesthesia, peripheral neuropathy, vomiting, and anaemia. Rarely, rhabdomyolysis and hepatitis/jaundice occurred. An apparent hypersensitivity syndrome has been reported rarely which has included some of the following features: angioedema, lupus-like syndrome, polymyalgia rheumatica, vasculitis, thrombocytopenia, eosinophilia, ESR increased, arthritis, arthralgia, urticaria, photosensitivity, fever, flushing, dyspnoea and malaise.
Marked and persistent increases of serum transaminases have been reported infrequently. Liver-function test abnormalities have generally been mild and transient.
The causal relationship being unknown: Depression, erythema multiforme including Stevens-Johnson syndrome, leucopenia and purpura.

Marketing Authorisation Holder
Approved Prescription Services Ltd.
Marketing Authorisation Number
PL 0289/0379
PL 0289/0380
PL 0289/0381
Legal Classification
POM
Price
Simvastatin 10 mg Tablets, pack size 28 = £17.13
Simvastatin 20 mg Tablets, pack size 28 = £28.21
Simvastatin 40 mg Tablets, pack size 28 = £28.21
Date of Preparation
March 2003

as branded ethicals and parallel imports. There is a real risk that the competitively driven generies market will be unnecessarily disrupted without any net reduction in the overall cost of drugs to the NHS.

"While it is clear that wholesalers and pharmacists will remain the major contributors to savings created by any new arrangement, sueh an arrangement must remain simple, easily understood and eheap to administer. It should also allow a free market to operate. Market pressures from pharmaeists have traditionally driven prices down, generating the continuing eyele of saving for the NHS.

"The other, more eomplex, pricing eontrol meehanisms suggested for generic medicines have failed to aehieve any consensus or find favour with the various elements of the supply ehain, and should be abandoned.

"With the increasing range and influenee of generic drugs in the market, pharmacists' traditional purehasing patterns are ehanging from irregular bulk buying to the replacement on demand, as with ethieal products. This trend is being encouraged by generie manufacturers as they move away from direet distribution.

"For its sueeess, the market will depend increasingly on the high quality, twiee daily delivery serviee offered by full line wholesalers, who will play an inereasingly important role in the supply of generics."

However, Richard Daniell, direetor of UK generics at Ivax Pharmaceutieals UK, says: "Ivax fully supports the objeetives for the new scheme for the supply and reimbursement arrangements outlined in the Government's consultation document and we welcome the move towards greater transparency in arrangements.

"Whilst not wishing at this stage to comment on the complex detail of the proposal we do recognise that we are at the beginning of a signifieant change in pharmacy praetice and the interests of independent pharmacists continue to be of paramount importance to us.

"Ivax is the market leader in 'first to market' generics for all patent expiry produets. Aeros all the products that Ivax plans to sell in 200 including our new produet launehes, at least £130m will be saved by the NHS versus the brand originator produets.

"A future area of growth for pharmacists t look towards is supplementary preseribing. W are at the beginning of a significant ehange i pharmacy praetice an the pharmaeists' ro and influenee within the healthcare provision team Providing a sure-fire way guaranteeing that the preseription will be dispensed fro the

"Pharmacists expect frequent delivery as well as rock bottom prices"

Tony Foreman

A growing commitment to specials

supplementary prescriber's pharmacy, the business's revenue stream will ultimately be enhanced. Ultimately I would like to see pharmacists paid an additional fee for the provision of their professional services in this manner. Only 1,000 pharmacists are involved at present but this is still an exciting step forward for pharmacy."

Tony Foreman, Alliance UniChem's European development director generics, agrees that the UK generics market is a tough one as prices continue to decline, saying: "For example omeprazole moved from £18 at launch to £7.70 in five months. Sixty per cent of the market is shortline and research [commissioned by OTC Direct in August 2003 conducted with over 400 pharmacies] showed expectations are high. Pharmacists expect frequent delivery as well as rock bottom prices. The average generic trade price is just £1.70.

"With regard to choice of product, prior to the launch of Almus in April 2003, extensive research identified what was desired. The research identified that pharmacists are divided into two distinct groups with regard to their motivators for purchasing generics; they are driven by either price or continuity.

"The Almus range provides pharmacists with a brand that satisfies these buying patterns. This is set to continue as it increases its product range further, with coproxamol tablets 32.5/325mg the latest addition.

"Across Europe, generics are becoming increasingly important. The Almus brand, exclusive to OTC Direct and UniChem, uses its scale and scope of operations to work with global manufacturers to drive value for all parties in the supply chain. As pressures fall on all parties in the healthcare sector, one of Almus's key roles is to use this scale, as far as we are able, to ensure the stability of the supply channel, protecting individual pharmacists who might otherwise not be able to compensate for a margin squeeze or a clawback rise. I do not see any let up on the pressure put on generics in wholesale. The way forward is for wholesalers to ensure they are working hard at sourcing to secure best costs in order to ensure they can maintain competitiveness in the market."

Peter Ballard, sales and marketing director at Genus Pharmaceuticals, agrees the market for generics is developing but claims it is now at a crossroads. He says: "If it turns left and is sensible and accepts the new reimbursement proposals it stands to create a better, more stable business. If it turns the other way and behaves as it always has, competing for market share rather than business stability, it will destroy itself and ultimately be bad for patients.

"Genus is very passionate about the role that pharmacy plays in healthcare, and as such believes Discovery gives a fair return to all stakeholders. The market should be making money but not by bullying manufacturers into discounting down to nothing. If pharmacists are only sitting in their back rooms looking for the cheapest prices they will put themselves out of business.

"I want to see everybody win here. If stakeholders see the reimbursement proposals as a bigger picture, it will work for everyone."

The specials market also continues to see a growing demand. Amanda Ackroyd, commercial manager at BCM Specials, believes this growth has been driven by the "clear benefits" of ordering from a specials manufacturer.

She says: "Ordering from a specials manufacturer can free up more time for the pharmacists to spend with patients. This reduces the time spent obtaining raw materials, completing the necessary extemporaneous dispensing records and ensuring the requisite equipment and facilities are available, not to mention actually making up the preparation.

"BCM Specials has certainly seen significant growth in recent years and so confident are we in future growth that we have invested £1m this year on expanding our production facilities and on introducing new computer systems."

Fiona Cruickshank, managing director of The Specials Laboratory, claims the modernisation of the hospital manufacturing services industry which started in 2002 has impacted greatly on the industry. "We are playing a highly proactive and important role", she says. An NHS multi-disciplinary Implementation Board was set up in England to lead this modernisation process.

Continued on page 36 ▶

Consequently, £42m of capital has been earmarked and is available in 2004-2006 for investment in the manufacture of hospital medicines. Hospital units are in the process of bidding for a share of the capital.

"The NHS board has identified the need to work with industry partners in order to drive modernisation. As a direct result of this a new group, the Association of Commercial Specials Manufacturers, was formed.

"The Specials Laboratory works alongside other member organisations and plays an active role in this group which brings together representatives from interested parties. The association is drawing up general principles for working with the NHS to assist in the delivery of these medicines to patients with specials needs. We are currently discussing risk management issues and partnership models which are already in place."

"The market for specials will continue to grow as patient needs become more complex"

Fiona Cruickshank

She adds: "In general the market for specials will continue to grow as patient needs become more complex and therapy is tailor-made for individuals.

"A significant market for The Specials Laboratory is paediatric medicines and our product development team has worked hard to improve the flavouring of paediatric formulations for patients. Stability work for specials has become a large part of our work in the past year. The company works with pharmacists to develop new formulations and specialised packaging for their patients and is about to complete analytical studies to extend shelf life."

However, Jonathan Fawdry, director and general manager of Eldon Laboratories, believes the specials industry has matured to the point that it is now experiencing similar competitive pressures and behaviours of customer and player that apply to many othe established markets. "Therefore the new contract is likely to have a big impact on hov the market develops," he says.

"Eldon, with its intimate understanding o frontline pharmacy, is best placed to assist th pharmacist as he takes on new roles. It is our creative and innovative support and solution to many of the special issues the pharmacist has had to deal with as the industry has grov that has helped us achieve our position.

"Eldon continues to invest heavily in staff facilities and systems to ensure, long term, t high levels of product quality and service th the pharmacist expects and needs.

"Community pharmacy needs sustainable long-term partnerships with effective specia manufacturers and this should be the driver for buying decisions now and in the future."

It would appear that suppliers are keen to show their support for pharmacists, but the fact remains that those involved in the supply of generics and specials believe the DoH must fully acknowledge the enormous contribution that manufacturers, wholesalers and pharmacists make in reducing NHS drug costs through their supply.

For more information: *www.britishgenerics.co.uk*

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Award for 'speed king' pharmacist

Leicester locals may recognise the face smiling out from the crash helmet, especially as he has been named a runner-up in the recent *Leicester Mercury* newspaper's 'Hands on Health' awards.

However, Terry Mattock of A F Mattock Pharmacy, Leicester, nearly didn't make it to the awards ceremony at all. He only learnt he had been named a finalist in the 'therapist' section when he was told by colleagues at a local branch meeting, and then his letter from the local paper inviting him to the awards ceremony at Leicester Racecourse went astray. However, a phone call from the *Mercury* soon unearthed the problem and he managed to make it to the evening where he was presented with a certificate.

As pharmacists have never previously featured in the awards, Terry felt it was a "welcome boost" for the profession, and was delighted with the recognition the award has given him.

Mr Mattock is often seen on his motorbike delivering medication to his patients – now he just needs to work out where his "high speed delivery service" fits into the new pharmacy contract...

A day at the races

The Numark Handicap Hurdl sponsored by Phoenix, feature as the first televised race on th card at Bangor-on-Dee last we

Simon Colebeck, Numark Trading Ltd's new managing director and his wife Suzanne were on hand to present the prize to the winning owner, Mrs P Sherwood, whose horse Whaleef, ridden by T Doyle, came in at 7-1.

Pharmacists present at the races included Martin Oldfield from Johnstown, near Wrexha and his wife Beth, and Barry Pearson and his wife Ann from Burnley. The four had judged best turned-out horse earlier i the day and that prize went to Risky Way.

The Phoenix Race Day is becoming an increasingly popu event. David Cole and his wife Kim hosted the event, attended over 130 customers and suppli in Phoenix's private marquee.

Pictured are NTL managing director Simon Colebeck and his wife Suzanne presenting the pri for the Numark Handicap Hurdle winning owner Mrs P Sherwood

I couldn't possibly comment, Minister

C&D is in a quandary. We have been wondering quite what former Minister without Portfolio Peter Mandelson was saying to Lloydspharmacy's superintendent pharmacist Andy Murdock at the recent Labour Party Conference in Bournemouth.

Is Andy smiling because Mandy has given him some good news about the outcome of the control of entry saga, or was Mr Mandelson just regaling a particularly amusing story about house-buying in Notting Hill?

Hopefully our readers may be able to offer a clue. We're offering a bottle of fizz for the wittiest among you budding Champagne Socialists.

Please feel free to send suggestions of what one Mr M might be saying to the other Mr M to *chemdrng@cmpinformation.com*. Remember, though, keep them clean – you wouldn't want a visit from Mandy's mate, the deputy Prime Minister, would you?

A flight to Jersey in the springtime

Pharmacist Nora Taylor will be flying to Jersey for a three-night weekend break next spring courtesy of Pharmacy Travel.

Nora, who works at Curries Pharmacy in Tonbridge, Kent, is the lucky winner of the September Pharmacy Travel prize draw, and is looking forward to her break in St Helier, the island's capital. She had completely forgotten sending in the entry coupon, so news of her good fortune was a complete surprise.

You have until October 27 to send in this month's prize draw coupon to win a Historic Hotel break at a superb country mansion. And look out in *C&D* and *Community Pharmacy* for next month's Pharmacy Travel, which could see you taking a trip to Dublin!

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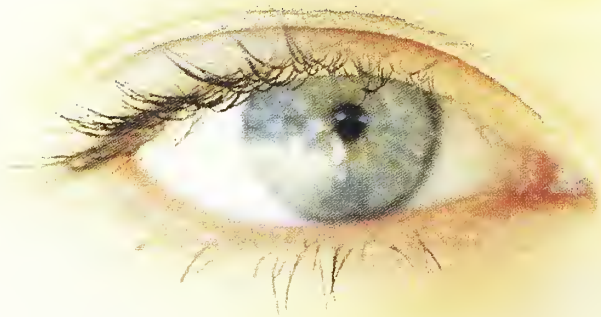

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Dosage and Administration
Although Co-cyprindiol acts as a contraceptive, it should not be used in women solely for contraception, although when taken, additional hormonal methods of contraception are not usually required.

One tablet daily for 21 days, starting on the first day of the menstrual cycle (the first day of menstruation counting as day one). There should be 7 tablet free days between courses. Should bleeding fail to occur in the tablet-free interval, the possibility of pregnancy must be excluded before the next pack is started.

When changing over from a different oral contraceptive there are specific instructions that must be followed (see Summary of Product Characteristics). This is also applicable to post-partum and post-abortum use.

There are certain circumstances where additional contraception may be necessary. Such cases could be after incorrect administration either by missing a tablet, taking a tablet more than 12 hours later than the usual time, or after vomiting or diarrhoea.

Contraindications
Pregnancy or lactation. Severe disturbances of liver function, jaundice or persistent itching during a previous pregnancy, Dubin-Johnson syndrome, Rotor syndrome, previous or existing liver tumours. Personal or family history of confirmed idiopathic venous thromboembolism (VTE). Current venous thrombotic or embolic processes. Existing or previous arterial thrombotic or embolic processes; or severe or multiple risk factor(s) for venous or arterial thrombosis. Sickle cell anaemia. Mammary or endometrial carcinoma, or a history of those conditions. Severe diabetes mellitus with vascular changes. Disorders of lipid metabolism. History of herpes gestationis. Deterioration of otosclerosis during pregnancy. Undiagnosed abnormal vaginal bleeding. Hypersensitivity to any of the tablet components.

Special Warnings and Precautions
Venous thromboembolism occurs more frequently in women taking Co-cyprindiol than those taking a low-dose combined oral contraceptive. Before starting therapy, patients should be evaluated for risk factors such as hypertension, relevant family history, diabetes or glycosuria. Drug interactions (e.g. with hepatic enzyme inducers, antibiotics, St John's Wort) may interfere with the contraceptive efficacy of Co-cyprindiol.

Side effects
Increased risk of venous thromboembolism.In rare cases headaches, gastric upsets, nausea, vomiting, breast tenderness, changes in body weight, changes in libido, depressive moods can occur. In predisposed women use of Co-cyprindiol can sometimes cause chloasma, which is exacerbated by exposure to sunlight. Poor tolerance to contact lenses. Menstrual changes can occur, such as; reduction of menstrual flow, missed menstruation, intermenstrual bleeding. There may be an effect on various blood chemistry tests.

Legal Category
POM

MA Number
PL 08137/0081

MA Holder
Neolab Limited, 57 High
Odiham, Hants, RG29 1

Trade Price
£11.10 (3 x 21 tablets)

Pack Size
63 Tablets

Date of preparation
July 2003

Further information is provided in the Summar of Product Characteristi which is available from t MA Holder.